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ABSTRACT

This manual is intended to provide mental health professionals with the information needed in the evaluation and treatment of maltreated children and their families. An introductory chapter briefly considers the roles of the various mental health disciplines in child abuse intervention, including psychiatry, psychology, clinical social work, psychiatric nursing, counseling, art therapy, and child abuse intervention as a subspecialty. The next chapter looks at specific roles of the mental health professional in primary and secondary prevention, tertiary intervention, evaluation and treatment, and advocacy. Next the responsibilities of the mental health professional are delineated for such concerns as reporting child abuse and neglect, referring children for medical evaluations, and establishing quality assurance practices and standards. The chapter following is devoted to definitions of child abuse and neglect and covers operational definitions, incidence estimates, effects of child abuse, physical abuse, sexual abuse, neglect, and assessing suicide risk. Mental health treatment issues and models discussed in the fifth chapter include intrafamilial child sexual abuse treatment, nonfamilial child sexual abuse treatment, self-help groups, and neglecting families intervention. The last chapter examines treatment modalities and covers procedures of the justice system, the therapeutic environment, confidentiality, and supervision. Attached are a glossary of terms and addresses of victim assistance programs. (Contains 30 references.) (DB)

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The Role of Mental Health Professionals in the Prevention and Treatment of Child Abuse and Neglect

The User Manual Series

EC 302563

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families
Administration on Children, Youth and Families
National Center on Child Abuse and Neglect

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The Role of Mental Health Professionals in the Prevention and Treatment of Child Abuse and Neglect

Marilyn Strachan Peterson
Anthony J. Urquiza

1993

U.S. Department of Health and Human Services
Administration for Children and Families
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PREFACE

The Child Abuse Prevention and Treatment Act was signed into law in 1974. Since that time, the Federal Government has served as a catalyst to mobilize society's social services, mental health, medical, educational, legal, and law enforcement systems to address the challenges in the prevention and treatment of child abuse and neglect. In 1977, in one of its early efforts, the National Center on Child Abuse and Neglect (NCCAN) developed 21 manuals (the *User Manual Series*) designed to provide guidance to professionals involved in the child protection system and to enhance community collaboration and the quality of services provided to children and families. Some manuals described professional roles and responsibilities in the prevention, identification, and treatment of child maltreatment. Other manuals in the series addressed special topics, for example, adolescent abuse and neglect.

Our understanding of the complex problems of child abuse and neglect has increased dramatically since the user manuals were first developed. This increased knowledge has improved our ability to intervene effectively in the lives of "at risk" children and their families. For example, it was not until the early 1980's that sexual abuse became a major focus in child maltreatment research and treatment. Likewise, we have a better grasp of what we can do to prevent child abuse and neglect from occurring. Further, our knowledge of the unique roles key professionals can play in child protection has been more clearly defined, and a great deal has been learned about how to enhance coordination and collaboration of community agencies and professionals. Finally, we are facing today new and more serious problems in families who maltreat their children. For example, there is a significant percentage of families known to Child Protective Services (CPS) who are experiencing substance abuse problems; the first reference to drug-addicted infants appeared in the literature in 1985.

Because our knowledge base has increased significantly and the state of the art of practice has improved considerably, NCCAN has updated the *User Manual Series* by revising many of the existing manuals and creating new manuals that address current innovations, concerns, and issues in the prevention and treatment of child maltreatment. This manual is intended to provide a foundation for mental health professionals, to broaden their roles and responsibilities, and to discuss the issues that should be considered in the evaluation and treatment of maltreated children and their families. This manual may also be used by other professionals to increase their knowledge about the work of mental health professionals and to improve the ability of all social services disciplines to work together collaboratively.

ACKNOWLEDGMENTS

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INTRODUCTION

THE MENTAL HEALTH PROFESSIONAL AND CHILD ABUSE

Mental health professionals promote healthy human development and functioning through clinical work and/or teaching and research. Their professional expertise includes personality theory; stages of human development; normal and abnormal psychology; personality traits, disorders, and psychopathology; the interactional influence of the family, peers, and the community; the effect of social, historical, and economic periods upon attitudes, values, and behavior; and therapeutic modalities and interventions with children, adults, and families.

It is common for mental health professionals to encounter clients with either a childhood history of abuse or neglect, or a suspicion of or actual evidence of current abuse. Childhood histories of emotional, physical, or sexual abuse or neglect and the subsequent development of maladaptive traits and behavior are at the root of many clients' presenting problems. These faulty or injurious childhood relationships with primary caretakers exist on a continuum of low to high adverse impact. Child maltreatment affects personality development, interpersonal relationships, school and job functioning, and the development of chronic life adjustment problems, personality disorders, psychopathology, and multiple personality disorders. For these reasons, it is essential that mental health professionals:

- know the definitions, dynamics, and effects of all forms of child maltreatment;
- understand how contextual (environmental) and developmental factors affect the experience; and
- obtain specialized training to provide effective clinical intervention for children and their families.

MENTAL HEALTH DISCIPLINES AND CHILD ABUSE INTERVENTION

Mental health professionals include several disciplines with varying professional orientations, length of education/training, and clinical supervision requirements for licensure and/or clinical practice. Psychiatrists, psychologists, and clinical social workers have the most extensive specialized training in child abuse and neglect. Other mental health providers, depending on State and local practice, may include psychiatric nurses, counselors, and art therapists.

Psychiatrists, psychologists, and clinical social workers engaged in therapeutic intervention with children and families provide clinical evaluations, psychotherapy, consultation to child protective service (CPS) agencies, and expert testimony in court. The main differences among these professions are the scope of the evaluation performed, the degree of case difficulty requiring specialized training and expertise, the ability to prescribe medications, the training and expertise to administer and interpret psychological testing, and training in experimental and applied research. Mental health professionals employ approaches similar to psychotherapy by drawing upon theories of personality development and theories regarding cognitive, behavioral, and emotional functioning of clients. These intervention models and approaches have a foundation in modern psychoanalytic, psychodynamic, and cognitive theory and incorporate other theories as appropriate (e.g., object relations and attachment theory, role theory, learning theory, family systems theory, and behavioral theory).

Psychiatry

Psychiatrists have a medical degree and a 3- to 4-year residency training program in psychiatry. They are the only mental health professionals legally authorized to prescribe any medications. Both psychiatric residency training and elective postresidency fellowship training focus on working with either adults or children. The cornerstone of child psychiatric training is the body of knowledge about child development.

Psychiatrists provide evaluation and treatment of children, adults, and families. Although it involves a range of referrals, a psychiatric assessment is helpful with parents and children in cases involving:

- a previous psychiatric history;
- psychotic symptoms such as hallucinations, delusional thinking, or bizarre ideation;
- suicidal ideation or attempts;
- severe anxiety and depression;
- periods of unconsciousness, i.e.,"blackouts";
- aggressive outbursts;
- aberrant relationships;
- developmental delay;
- behavioral symptoms, such as anorexia nervosa or bulimia; or
- psychosomatic illness, dramatic, or histrionic symptoms.[1]

Psychology

Psychologists either have a doctorate in philosophy, which emphasizes both clinical training in psychology and training in scientific research, or they have a doctorate in clinical psychology, in which the primary emphasis of training is clinical work rather than research. The average length of graduate training is between 5 and 7 years. Psychologists may also complete postdoctoral training programs to acquire more advanced clinical training and/or training in research.

Psychologists provide evaluation and treatment of children, adults, and families. They are the only mental health professionals accredited to perform psychological testing and evaluation. Psychologists employ a battery of tests that evaluate cognitive functioning (how one regards and understands the world), affective functioning (emotions and fantasies), adaptive functioning (how feelings and skills are employed to deal with the challenges and tasks life presents to an individual), and pathological functioning (ways in which the individual's internal conflicts and drives distort or overwhelm the ability to deal effectively with the demands of external reality).

Psychological testing can address these questions about an individual:

- What are the client's intellectual strengths and limitations?

- Is there evidence of neurological immaturity or impairment?
- What is the nature of past knowledge and achievements, interests, and aptitudes?
- How adequate is reality testing?
- What is the quality of interpersonal relationships?
- What are the adaptive strengths (application of assets and liabilities to new problems; flexibility of approach, persistence, frustration tolerance, and reaction to novelty)?
- To what degree are impulses maintained under control (undercontrolled, overcontrolled)?
- How does the person defend psychologically (protect the self from feelings, ideas, and experiences that create anxiety through avoidance, repression, etc.) against unacceptable internal needs and demands or external experiences? How rigid are the client's defenses?
- What are the areas of conflict?[2]

Clinical Social Work

The social work master's degree is versatile and enables social workers to be involved as practitioners and administrators in a range of subspecialties (e.g., CPS, medical social work, corrections, community organizations, and clinical practice). For the purposes of this manual, the focus will be on clinical practice or the provision of assessment and psychotherapy.

In most States, clinical social workers possess a 2-year master's degree and postdegree requirements for clinical supervision. The historical orientation and distinguishing characteristic of social work training is to view the client in the context of intrapersonal, interpersonal, and intersystemic functioning.[3]

Master's level social workers are often actively involved in multidisciplinary training. They tend to have less involvement in research because the emphasis of the master's degree is on clinical practice. Social workers obtain doctorates in social work to pursue university-level teaching, train in research design and methodology, and develop expertise in research-based public policy setting. There are doctorates in the clinical practice of social work; however, the majority of social workers practice with a master's degree.

Psychiatric Nursing

Psychiatric nurses are involved in clinical practice with a nursing degree, a master's degree, and postdegree requirements for clinical supervision in most States. They may work in outpatient clinics but are more often employed in inpatient units. Nurses obtain master's degrees and/or doctorates in nursing to pursue careers involving teaching, research, or health policy development.

Counseling

Counselors may or may not have a master's degree depending on the requirements of the State in which they practice and the level of complexity of the work they perform. Some social service agencies employ and train counselors with a bachelor's degree to provide crisis intervention, problem solving, client support, service referrals, and advocacy for social services or criminal justice intervention. The master's degree is

most often obtained in counseling psychology or a related field. In some States, counselors working with children and families obtain their licensing as marriage, family, or child counselors.

Art Therapy/Expressive Arts Therapy

Art therapists or expressive arts therapists are professionals who have combined interests in psychology and art. They typically practice with a master's degree in art therapy or psychology and art. A variety of art forms such as drawing, painting, sculpting with clay, sandplay, making puppets and art projects, or woodworking are used. Poetry, drama, movement, and music may also be part of this treatment modality. Traditional verbal communication during assessment and treatment may demand a skill or developmental level not always available to the child. Art therapy helps to meet children's needs by:

- facilitating the development of a therapeutic relationship;
- creating a medium for children to express feelings of fear, pain, anger, anxiety, and conflict in a manner less threatening than verbal expression;
- building feelings of self-acceptance and self-confidence; and,
- helping children learn communication and coping skills.[4, 5]

Child Abuse Intervention as a Subspecialty

Child abuse intervention has emerged as a subspecialty in many disciplines over the past 30 years. Social work, law enforcement, and the judiciary have the longest history of specialization with the establishment of CPS and juvenile officers investigating child abuse and neglect cases and the Juvenile or Family Court to adjudicate the cases.

For mental health professionals, the dramatic increase in cases and in attention to the problem of sexual abuse has led to clinical specialization with child victims and adult survivors of sexual abuse. As a result, a new term to characterize this work has been coined: "abuse-focused therapy." Abuse-focused therapy focuses on the original abuse context as one of the key issues in treatment, relating this trauma to later and current experiences and behavior. This perspective assumes that childhood abuse or neglect is relevant to a variety of child, adolescent, and adult mental health problems and that therapeutic attention to these events will have a significant impact on current psychological functioning.[6]

Effective therapeutic interventions for physically abusive and neglecting parents have also been developed by mental health professionals. Examples include standardizing parenting education curricula for parents ordered by the court to attend classes as a condition of family reunification, expanding didactic parenting education to include adult-child group play sessions facilitated by staff to teach parents how to interact with and discipline children, refining home-based services programs as intervention methods for physically abusive and neglecting parents, supporting the development of self-help groups, and targeting supportive and home-based services for high-risk mothers during the pre- and postnatal periods.

Other evidence of the emergence of child abuse and neglect as a subspecialty is the organization of national and statewide professional associations based on a multidisciplinary membership of mental health, social work, medical, and criminal justice professionals and the judiciary. Professional journals that specifically focus on child abuse and neglect and/or victimization are another important development because they keep the field updated on new research. Since clinical practice with child abuse victims and their families has

entered its third decade, there has been a substantial increase in the number of books and journals written by experienced clinicians and researchers on the psychodynamics of abuse and neglect, therapeutic interventions, and treatment modalities. Child abuse intervention as a subspecialty in mental health could be strengthened if basic and advanced training were offered in undergraduate- and graduate-level courses, if courses in child abuse and neglect were required for those applying for licensure and license renewal, and if licensing examination questions on this subject were required for all mental health disciplines.

ROLES OF MENTAL HEALTH PROFESSIONALS WORKING WITH ABUSED AND NEGLECTED CHILDREN AND THEIR FAMILIES

PRIMARY AND SECONDARY PREVENTION

Mental health professionals may be involved in primary and secondary prevention depending on their interests and expertise. Primary prevention is directed toward preventing a problem from ever occurring. Broad-based public awareness, media campaigns, and school-based prevention programs are examples of effective means of educating the public about health and social concerns. Secondary prevention is targeted at a specific high-risk subpopulation or group. Examples include home visitor programs for mothers of newborns identified at the hospital as being "at risk."

TERTIARY INTERVENTION

The primary focus of mental health professionals' training is tertiary intervention through the provision of therapeutic services to clients with a psychological problem that impairs their day-to-day functioning and relationships with others. In the field of child abuse and neglect, this involves working with both child victims and parents who abuse or neglect their children. Therapeutic interventions with children are directed toward preventing the harmful effects of child maltreatment. Therapeutic interventions with abusive parents are directed toward preventing recidivism through education, developing problem-solving skills, providing cognitive and behaviorally oriented counseling to prevent maltreatment, helping parents identify when they are at risk of abusing or neglecting their children, and teaching parents how to obtain support and resources to prevent abuse and neglect. The following roles briefly describe the activities in which clinicians are involved as a result of providing tertiary intervention or therapeutic intervention with clients.

EVALUATION AND TREATMENT

The primary role of mental health professionals in cases of child abuse and neglect is evaluation and treatment of children, nonoffending parents, abusive or neglecting parents, and/or the family as a unit. Mental health professionals often specialize by working either with children, adolescents, or adults and by working with victims or offenders. Professionals with expertise in working with adults typically limit their practice to adults. Child and adolescent therapists, however, must also be knowledgeable about how to work with parents and families.

Treatment begins by developing a therapeutic relationship, evaluating the overall functioning of the client, and planning treatment goals and intervention strategies based on the initial and ongoing assessment of client needs. Services for children and their families may be limited to crisis intervention and referral, brief therapy (10 to 12 weeks), or long-term therapy. Treatment modalities vary and may include individual and group therapy for children and parents, family therapy, and marital therapy. Group therapy may include victims grouped by type of victimization, age, gender, or sibling group; or parents grouped by their role as offending or nonoffending adults.

The frequency and length of treatment are often determined by financial considerations such as health insurance, grant or contract funding for the treatment program, or whether the client is eligible for participation in the State's Victims of Crime Program. Every State has a Victims of Crime Program under which crime victims' expenses for medical and psychological services can be reimbursed by applying to the program and meeting eligibility criteria. (See Appendix A for a listing of State Victims of Crime programs.)

Evaluation and treatment are reviewed in this manual's sections entitled "Mental Health Evaluations" and "Mental Health Treatment Issues and Models." The traditional therapeutic role expands when working with child abuse and neglect cases to include that of an advocate, information and referral source, educator, consultant, and member of a multidisciplinary team.

ADVOCATE

An advocate enables clients to become aware of their needs; receive competent intervention and decisionmaking by social services, criminal justice, and mental health personnel; and receive fair and equitable treatment. The number of cases, the many variables associated with child abuse and neglect cases, and the complexity of the system designed to serve children and families create the need for client advocacy. Individual client advocacy involves providing referrals, emotional support, assistance, and sometimes accompanying clients to other agencies to enable clients to obtain resources, services, and fair treatment.

Mental health professionals may also be involved in program advocacy or public awareness activities to promote improved or expanded services, increase funding for services, provide greater access for clients to services, develop new approaches to prevention and intervention, or prevent the elimination or reduction of services. Advocacy may also take the form of promoting new or revised laws, State regulations, or social policies. This type of change is most often accomplished through analysis of existing problems and/or research to establish a basis for proposing change. These proposals can be initiated by individuals but are most often brought about through coalitions and associations of professionals from single or multiple disciplines.

SOURCE OF INFORMATION AND REFERRALS

Clients and their families may have needs that cannot be met through traditional therapy. These clients may need referrals to parenting classes, parent aide programs, homemaker services, alcohol and drug treatment programs, self-help groups, battered women shelters, rape crisis centers, medical and legal services, tutoring services, victim/witness programs, offender treatment programs, and services for children with special needs such as hearing or vision problems or learning or developmental disabilities. Some communities have service directories; otherwise, it is useful to develop a local referral list.

EDUCATOR

The role of educator is performed on several levels. Part of psychotherapy involves education of the client regarding family and interpersonal dynamics; abuse and neglect dynamics; psychological and behavioral signs of abuse and neglect; information regarding child abuse investigation procedures; and Juvenile, Family, or Criminal Court proceedings.

Mental health professionals are also involved in the education and training of professionals from their own as well as other disciplines such as medicine, law enforcement, prosecution, and the judiciary. Mental health professionals may also be involved in public education through the media, community meetings, and forums.

PREPARING CLIENTS TO TESTIFY IN COURT

Children and adults experience anxiety about testifying in court. Part of the victim–witness advocates' role is to prepare clients to testify in court. In communities without such services or in situations not handled by advocates, other professionals such as therapists, police officers, or CPS social workers may provide support. Anxiety and ambivalence about testifying can be reduced by familiarizing the client with court procedures; the courtroom setting; and the roles of the judge, prosecutor, defense attorney, bailiff, and court reporter.

CONSULTANT TO COUNTY OR STATE DEPARTMENTS OF SOCIAL SERVICES

County and State Departments of Social Services make referrals to mental health professionals for assessments and treatment most often at one of three points during intervention in the child protection system. The first point is during the CPS investigation but prior to the adjudication or dispositional hearing. The purpose of this referral may be to obtain a psychological evaluation of the child to assess the mental health status of the child as a result of the abuse or neglect, or to obtain a psychological evaluation of the parent to assess the capability or nature and extent of the disabilities of the parent. These assessments are used to develop case plans and to support the agency recommendations regarding the disposition of the case.

The second point in time may occur after the adjudication or dispositional hearing when the family is ordered to participate in court-ordered protective supervision or the child is removed from his/her family and placed in foster care. The purpose of the referral may be to request an assessment of the child because of behavior that raises concern, provide psychological treatment for the child and/or parent, or evaluate the effects of multiple failed foster placements.

The third point in time may occur after the parent has failed to comply with family reunification efforts or is assessed to be incapable of parenting the child, and the decision is made to proceed with termination of parental rights. Children may be referred for psychological assessment and treatment for preadoptive therapy or conjoint therapy with adoptive parents.

EXPERT WITNESS

Mental health professionals may be called to render an opinion or testify as an expert witness in Juvenile, Family, or Criminal Court. The purpose of the Juvenile or Family Court adjudication hearing is to determine whether the child needs protection through court-ordered supervision of the family or whether the child must be removed from the home for a period of time to establish conditions for parental action for family reunification. The mental health professional may be asked to testify either to provide support for social service agency recommendations in the case or, if the professional has been working with the parent, support the parent's objectives. This is usually not a jury trial but a hearing conducted by a judge. Mental health professionals are also called to serve as expert witnesses in criminal trials for the prosecution or the defense, if felony offenses are charged.

Expert witnesses have the following responsibilities:

- to provide objective testimony whether one is testifying for the prosecution or the defense;
- to be a scholar in the field or related fields, and be familiar with or have contributed to the literature in that field;
- to be an active or recently active investigator in the field, if testifying on research matters, or be an active or recently active clinician in the field, if testifying on clinical matters;

- to consider the role of expert witness as a minimal part of professional activity and not as a profession (in other words, the main activities of an expert witness should be those of scholar, clinician, teacher, or investigator in the field of expertise);

- to be aware of the legal and ethical impact of the testimony, and the importance and potential consequences of the testimony to the people involved in the case;

- to be aware of the basic elements of the law and the legal procedures with which the expert will be involved;

- to understand that it is the expert's job to provide information and/or render an opinion, not to win or lose the case, and, therefore, avoid becoming consumed with the adversarial atmosphere of the legal process; and

- to obtain all the facts from the attorneys and clients(s) to avoid being surprised by damaging information later in the legal process.[7]

RESPONSIBILITIES OF THE MENTAL HEALTH PROFESSIONAL

REPORT CHILD ABUSE AND NEGLECT

The requirement to report child abuse and neglect became public policy in all States by 1965 with the passage of the first child abuse reporting law, which only required physicians to report physical abuse. Since that time, neglect, emotional abuse, and sexual abuse have been recognized as injurious to a child's physical and mental health, and reporting laws were amended to include these forms of child maltreatment. Those professionals required by law to make child abuse reports also expanded over the years to include teachers, nurses, mental health professionals, social workers, school custodians, day care providers, and others who are in regular contact with children.

Mental health professionals are now required by law in all States to report child abuse and neglect. The specific language of the States' reporting laws vary, but they typically cover circumstances when one acquires knowledge of or observes a child under conditions that give rise to a reasonable suspicion of child abuse and/or neglect; or, when one has knowledge of or observes a child whom he or she knows has been the victim of child abuse and neglect. "Reasonable suspicion" definitions may vary, but it is generally considered to occur when it is objectively reasonable for a person to entertain such a suspicion, based on his or her training and experience.

The primary intent of these reporting laws is to protect children from abuse and neglect. The child identified in the report may not be the only victim in the family; other children may be abused or at high risk of maltreatment. The purpose of the social services and/or law enforcement investigation is to evaluate the circumstances of all children in the family. In troubled families, parents need help but may not be able to directly ask for assistance. The report of abuse may be a catalyst for bringing about change in the home environment which, in turn, may help lower the risk of abuse or neglect in the family.

The majority of States require that oral reports (telephone or in-person contacts) of suspected child maltreatment be made immediately to a specified authority, usually law enforcement or child protective services (CPS). Many States require that a written report follow the oral report. In other States, written reports are only required upon request. The time frame for submission of the written report varies from within 36 hours to 5 days after making the initial oral report.

Reporting laws also contain provisions to protect the identity of the person making the report and protect reporters from civil lawsuits and criminal prosecution resulting from filing a report. Civil and criminal immunity is provided as long as the report is made in "good faith." Most States have criminal and financial penalties for failure to report, and there is also a risk of civil lawsuit liability for failure to report. By requiring professionals to report suspected child abuse and neglect and by adding financial, criminal, and civil penalties for noncompliance, States and the Federal Government have made a strong policy statement that protection of children is important in our society and that there is a legal obligation attached to professionals employed in these professions.

In addition to State laws, most professional codes of ethics require that their respective disciplines report child abuse and neglect to authorities. Please refer to the chapter, "How Child Abuse and Neglect Is Defined,"

which contains operational definitions of child abuse and neglect, and the User Manual entitled *A Coordinated Response to Child Abuse and Neglect: A Basic Manual,* for further discussion of child abuse reporting laws.

Resistance To Child Abuse Reporting Laws

Making a report of suspected child abuse may be difficult. There may be doubts about whether the circumstances merit a report, how the parents will react, what the outcome will be, and whether or not the report will put the child at greater risk from angry parents. The best way to minimize the difficulty of reporting is to be prepared for the experience, to be knowledgeable about the reporting requirements, and to be aware of the CPS agency intake criteria and the response that is initiated by making a report.

The most frequent concern about reporting is whether reporting severs the trust that the client must establish in therapy. Not reporting has a greater potential to sever trust because the clients who are abusing children are showing, in action or words, that they need help. The real question is, "How can clients trust the mental health professional who fails to recognize their needs and avoids helping them?"

Parents who abuse children are out of control, and parents who neglect children need education and supportive services. For various reasons, the parents' internal controls and personal resources are unavailable to them. As a result, they need as many external controls and support as possible, until they are better able to utilize their own restraints and resources. The reporting law is an opportunity to set an external control and limit that clearly states, "The abusive or neglectful behavior is unacceptable and must stop." Most abusive parents do not want to hurt their children, and hurting them affects their own self-worth by reinforcing their worst fears about themselves. As the therapist models appropriate setting of limits, the parents may become better able to do the same with themselves and with their children.

Most parents will feel relief because external controls or limits have been introduced to stop abuse. Offering a matter-of-fact caring approach counters the parents' sense of secrecy and shame about the incident(s). By not responding to parents' clues or statements, the therapist gives the message that he or she does not take the abuse seriously, believes that it will go away by itself, or is willing to collude in keeping the abuse hidden.

Inappropriate Interventions

- **Threats**: Threatening the clients with a report gives the impression that reporting is a punishment and may further alienate the client from seeking needed services.

- **Bargaining**: Statements such as, "I won't report you this time, but if you do it again I'll have to" give the message that sometimes it is all right to be abusive, but other times it is not. Bargaining also undermines the client's view of the therapist and sends double messages that are confusing. The abusive behavior may also escalate in search of a limit.

- **Abandoning the client**: It is important to provide ongoing support to the client throughout the investigation and followup services.

- **Conducting one's own investigation**: Out of reluctance to report suspected abuse or neglect to authorities, mental health professionals have undertaken their own inquiries and investigation. This investigation delays the appropriate response by authorities and could result in continued victimization of the child. It is against the law not to report suspected abuse or neglect immediately, and the civil liability if the child is victimized during that period is significant.

WHETHER TO TELL THE CLIENT THAT THE MENTAL HEALTH PROFESSIONAL IS MAKING A REPORT

The law does not require mandated reporters to tell the parents that a report is being made; however, in the majority of cases, advising the client is therapeutically advisable. First, the therapist is employing clinical leverage by using authority to set a firm and necessary limit. Reporting responds to the parents' nonverbal plea for help. The therapist can reassure the clients that steps will be taken to help the parents regain control so that the abuse does not lead to serious injury or emotional trauma to the child. Second, if the therapist does not mention the report, there is secrecy and tension, which may result in the clients' feelings of suspicion, isolation, or betrayal. In some cases, reporting may elicit an extreme response from the clients. It is contra-indicated to inform parents about the report if the individual seems psychotic, has poor impulse control coupled with a history of violent behavior, has a problem with alcohol or drugs, or is likely to flee. It can be very beneficial to give clients the opportunity to make the reports themselves in the therapist's presence. A self-report, however, does not negate the therapist's mandate to report.*

REFER CHILDREN FOR MEDICAL EVALUATIONS

Neglected, physically abused, and sexually abused children should be referred for a medical evaluation if they have not received an examination prior to referral of the case to the therapist. Some communities have hospital-based child protection teams that perform these evaluations. Other communities rely on local hospitals or physicians in private practice.

Child sexual abuse medical/evidentiary examinations have emerged as a new form of medical expertise. Some States have protocols for medical examiners to follow. The purpose of the evaluation is to examine the child for forensic evidence of recent or chronic trauma, to assess the possibility of sexually transmitted disease and pregnancy, and to provide medical treatment. If a medical/evidentiary examination is not authorized by investigative agencies, a child should still be referred for a medical examination because children frequently have concerns that their body has been irreparably damaged by the sexual contact. Reassuring sexually abused children that their bodies are healthy is an important step in the recovery process.

Mental health professionals are often concerned about revictimization of the sexually abused child through an insensitive medical examination. Sometimes they have made the assumption that these examinations are traumatic and have given this information to parents and children without having inquired about how the examinations are performed. This type of communication creates anxiety for the children, increases the difficulty of examining young children, and can prevent medical examiners from performing a complete medical examination. If these concerns exist, it is important to first inquire about the quality of these exams in the community and the philosophy and practices of the medical providers. If, after making inquiry, concerns still exist, the local medical society or criminal justice and social service agencies can be notified and requested to make an inquiry into local resources and practices and compare them to established children's or university hospital-based programs with expertise in sexual abuse medical/evidentiary examinations.

PREVENT SEXUAL ABUSE OF CHILD AND ADULT CLIENTS BY THERAPISTS

Sexual contact between therapists and clients is considered ethical misconduct, and, in a few States, such activity is considered a criminal act subject to prosecution. In other States, sexual misconduct with clients is subject to review by licensing boards and is grounds for revocation of licensure. Civil suits have been

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*This section on resistance was adapted from *The California Child Abuse Reporting Law: Issues and Answers to Professionals* by Eliana Gil, Ph.D.

successfully brought against therapists by their clients. Therapists knowledgeable about sexual misconduct by other therapists have an ethical duty to report this conduct to licensing boards and investigative agencies.

ACQUIRE KNOWLEDGE, SKILLS, AND EXPERTISE THROUGH TRAINING

Expertise in the area of child abuse and neglect is best acquired through a combination of clinical supervision from experienced service providers, experience in actual treatment programs prior to practicing independently in the community, and training programs. Most training on child abuse and neglect is offered through Federal, State, and local professional associations, child abuse prevention organizations, or child abuse treatment programs.

ESTABLISH QUALITY ASSURANCE PRACTICES AND STANDARDS

Due to Federal and State funding requirements, community mental health clinics have established quality assurance standards. Community-based organizations may or may not have developed organizationally to this point. At a minimum, policies and standards regarding client intake and evaluation procedures, establishing treatment goals and plans, charting and record-keeping requirements, client confidentiality and release of information, and maintenance of records (including length of time records are kept after a client has completed receiving services) should be established. Clinical supervision and supervisor or peer review of client charts or records should take place on a regular basis. Mental health professionals working independently of an agency or clinic should consider regular clinical consultation groups with peers to stay in the mainstream of clinical practice and the literature and to avoid working in isolation.

PARTICIPATE ON A MULTIDISCIPLINARY TEAM

The need for multidisciplinary teams emerged over 30 years ago from the realization that no one discipline can successfully intervene in cases of child abuse and neglect cases. The first teams were established in 1958 at Pittsburgh Children's Hospital, the Children's Hospital in Los Angeles, and the University Hospital in Denver. Since 1958, the number of teams has grown throughout the United States. The focus of these university hospital-based child protection teams is to review all cases referred, provide training, and initiate research.

Today there are many different types of multidisciplinary teams. Some teams focus on investigation of cases and are based in a public agency rather than a hospital. These teams concentrate on discussing new cases to review findings and actions by all personnel (e.g., medical examination findings, CPS, and law enforcement initial investigation results). Prosecutors sometimes serve on these teams to report on filing decisions.

The purpose of this approach is to review cases to ensure a standard quality of intervention and coordination among agencies at the initial stages of a case. If high numbers of cases (20–30) are reviewed each week, there is limited feedback in the ensuing weeks as to individual case outcomes. Lower numbers of cases make outcome information feasible to obtain and discuss. Some communities have addressed this problem by establishing teams that specialize in different types of abuse (e.g., sexual, physical, or neglect). This approach, however, necessitates specialized personnel that only investigate one form of abuse—or assignment of personnel to more than one case review meeting per week.

If the team has a dual mission of case review and case planning, it will also include a public health nurse, a mental health representative from a community mental health clinic, a child abuse treatment program, or a practitioner in private practice. The focus of this team is also influenced by the number of cases. If the team reviews a high number of cases each week, the focus of the discussion is a review of decisionmaking to date, with a case planning discussion limited to recommendations. If the number of cases reviewed is more

manageable, the team will have time for case planning, feedback at later sessions regarding individual case outcomes, making additional recommendations, or revising case plans.

A few communities have teams that take a retrospective look at decisionmaking and randomly select past cases for review to evaluate how the child protective system is working. Cases are randomly selected from three points in the system: child abuse reports, prosecutor filing decisions, and placement of children in foster care. The review has several purposes: (1) to identify systemic or thematic problems that occur repeatedly at the time of intake, investigation filing and prosecution decisions, child protective custody and release actions, and foster placements; (2) to assess the quality of case planning ; and (3) to determine whether case plans were fully or partially implemented.

The focus of the review is to identify systemic or thematic problems that occur repeatedly at intake, investigation filing and prosecution decisions, child protective custody and release actions, and foster placements; review the quality of case planning; and assess whether case plans were fully or partially implemented.

Two new types of specialized multidisciplinary teams that have emerged are child death review teams and perinatal substance abuse teams. The purpose of child death review teams is to review all cases of child death in a community to determine whether they were abuse-related and, if so, to identify what could have been done to prevent the death. The purpose of perinatal substance abuse teams is to review cases of newborns with positive drug screens to evaluate whether the infants are at risk of abuse or neglect and to recommend needed social services.

It is commonly recommended that mental health professionals serve on multidisciplinary teams. At the same time, it must be recognized that, in many communities, these teams have evolved and changed, and their focus has become driven by the numbers of cases. Caseworkers have become service brokers securing the services of a cadre of mental health professionals in private practice, and it is not practical to include all of them on a team.

The basic premise of the team is that no one professional can respond to the complexity of these cases. In recognition of these changes, it is recommended that agency-based mental health professionals form review teams within their own organization and plan case reviews involving the families' caseworkers. Clinicians in private practice should consider regular case review meetings with caseworkers and peer consultation groups.

HOW CHILD ABUSE AND NEGLECT IS DEFINED

The Child Abuse Prevention and Treatment Act (Public Law 102-295) defines child abuse and neglect as the physical or mental injury, sexual abuse or exploitation, negligent treatment, or maltreatment:

- of a child, a person under the age of 18, or except in the case of sexual abuse, the age specified by the child protection law of the State;
- by a person who is responsible for the child's welfare, including any employee of a residential facility or any staff person providing out-of-home care;
- under circumstances which indicate that the child's health or welfare is harmed or threatened thereby.

Legal definitions of child abuse and neglect and child abuse reporting law requirements vary from State to State. Because mental health professionals are mandated by all States to report child abuse and neglect, they must be knowledgeable about reporting law requirements. Information about reporting requirements can be obtained by calling State or county child protective services (CPS) or a local law enforcement agency. The NCCAN publication entitled *Child Abuse and Neglect: A Shared Community Concern* contains a list of State CPS agencies; how to access county agencies if a State's child protection services are organized by county, telephone number(s), address; and procedures on how to make a child abuse report.

OPERATIONAL DEFINITIONS

The four types of abuse described below may occur alone or in combination. Physical and sexual abuse and neglect are not separate, discrete categories. They overlap in the experiences of many children and are linked to short- and long-term psychological sequelae.

Physical Abuse

Physical abuse is characterized by inflicting physical injury by hitting, punching, beating, kicking, throwing, biting, burning, or otherwise physically harming a child. The injury may be the result of a single episode or of repeated episodes. The physical trauma can range in severity from minor bruising, abrasions, lacerations, burns, eye injuries, and fractures to damage to the brain and internal organs (liver, spleen, abdomen, pancreas, and kidneys). Head and internal injuries are the leading causes of child abuse-related deaths. This form of abuse also includes extreme or bizarre forms of punishment such as torture or confinement of children in dark closets, boxes, or rooms for days, months, or even years at a time.

Sexual Abuse

Child sexual abuse includes a wide range of conduct: genital exposure; masturbation between adult and child; fondling breasts, genitals, buttocks, and thighs; oral copulation; vaginal or anal penetration by finger, penis, or foreign object; dry intercourse (rubbing penis between child's thighs or anal-genital area); and commercial exploitation through prostitution or the production of pornographic materials.

Children are more often sexually abused by someone responsible for their care than by strangers. The most commonly reported cases involve incest (sexual abuse occurring among nuclear family members) between father or stepfather and daughter. Mother–son, father–son, mother–daughter, and brother–sister incest also occurs. Sexual abuse may be committed by other relatives such as grandfathers, grandmothers, cousins, aunts, and uncles or by nonrelatives such as babysitters and day care providers, teachers, children's activity group leaders, neighbors, and friends of the family.

Sexual abuse may also involve multiple child victims by a group of offenders, sometimes involving satanic or ritualistic practices. Client histories of ritualistic abuse may include reports of torture, animal and human sacrifice, and homicide. Similar reports have surfaced in many States and should not be dismissed because they sound unbelievable.

Emotional/Psychological Abuse

Emotional abuse includes acts or omissions by the parents or other persons responsible for the child's care that have caused, or could cause, serious emotional, behavioral, cognitive, or mental disorders. Emotional/psychological abuse exists on a continuum of habitual behavioral interactions such as belittling through comments, comparisons, and name-calling; scapegoating; humiliating; isolating; screaming and raging; and psychological inaccessibility or rejecting treatment.

Child Neglect

Child neglect is characterized by failure to provide for the child's basic needs. Neglect can be physical, educational, or emotional.

- **Physical neglect** includes refusal of or delay in seeking medical or dental care, abandonment, inadequate supervision, passive drug intoxication with illicit drugs, accidental ingestion of illicit drugs, and expulsion from home or refusing to allow a runaway to return home.

- **Educational neglect** includes permission of chronic truancy, failure to enroll a child of mandatory school age, and inattention to a special educational need.

- **Emotional neglect** includes failure to respond to the child's psychological needs for attention, love, and emotional security; emotional deprivation and being psychologically inaccessible; exposure to chronic or extreme spouse abuse in the child's presence; and permission for drug or alcohol use by the child.

INCIDENCE

In 1990, States received an estimated 1.7 million reports of alleged child abuse and neglect of an estimated 2.7 million children. After investigation, more than 618,200 allegations involving more than 846,000 children were substantiated or indicated. Because definitions and criteria vary from State to State and data collection methods differ, it is difficult to obtain representative statistics. States do provide their annual data on child abuse and neglect cases to NCCAN, which publishes them as reports and working papers of the National Child Abuse and Neglect Data System.

A commonly asked question is whether the incidence of child abuse is actually increasing or whether public awareness has caused more people to report abuse and neglect. No one knows for sure; however, many of the causative factors in child abuse have not been ameliorated but have worsened. Social indicators include

poverty and unemployment rates; drug and alcohol abuse; school dropout rates; high incidence of low birthweight babies; stress; poor or inadequate housing; high divorce rates and resulting increase in single-parent households headed by women; teen pregnancy; and increased social isolation caused by decline of influence by the nuclear and extended family; by reduced participation in school, community or church activities; and the gradual disenfranchisement or dissociation of individuals from the community. For more information on the definitions and extent of child maltreatment, the reader is referred to another manual in this series entitled *A Coordinated Response to Child Abuse and Neglect: A Basic Manual.*

EFFECTS OF CHILD ABUSE

Child abuse and neglect have been found to be intergenerational in families, although not all maltreated children mature to become parents who abuse and neglect their children. In many families, however, models of parenting are passed on through the generations, and victims internalize or adapt the patterns of their victimizers. These parenting and intergenerational patterns can be changed or modified through education and effective treatment interventions with children and parents.

Child maltreatment by parents and caretakers has a significant impact on the organization and development of personality. The child development literature is clear that the most significant factor in children's lives is their relationship to their parents. Interactions from birth form this relationship, and the result is a continuum of high- or low-degree bonding, attachment, and family cohesiveness. Disruption and impairment of bonding and attachment directly affect the child's formation of internal beliefs about him/herself and others. The child's self-perception and subsequent responses and adaptations to the maltreatment affect personality development and how the child relates to others.

Contextual and Developmental Factors

Contextual (environmental) and developmental factors are important to consider in evaluating the impact of child abuse and neglect because they affect the variability in the experience of abuse by the child and the family's response to the abuse. These mediating variables prevent a simple cause-and-effect response to victimization. It is possible to identify certain maladaptive responses that occur with high frequency (sexualized behavior, aggressive behavior, or passive or withdrawn behavior) in studies of sexually and physically abused or neglected children. Despite the frequency, the mediating variables make it impossible to predict that the behavioral indicators listed below will be present in every abused and neglected child. Examples of contextual variables include:

- family dynamics and constellation (e.g.,whether both or only one parent was abusive, the quality of the relationship with the nonabusive parent, the presence of drug or alcohol abuse, level of cohesiveness among siblings, support or nonsupport by extended family members, and number of siblings);
- abuse characteristics (e.g., type, frequency, and duration of the maltreatment, whether physical injury, illness, or disability resulted from the maltreatment);
- social and emotional support systems (e.g., mental health status of parents, quality of the marital/partner relationship, isolation or access to other supportive individuals such as relatives, neighbors, friends);
- neighborhood and community environment (e.g., social cohesiveness, access to community services, community safety, existence and effectiveness of public agency intervention); and

- school environment (e.g., relationships with peers and teachers, school attendance and achievement, access to extracurricular activities).

Examples of developmental considerations are:

- age and developmental stage of the child at the time of the maltreatment;
- intellectual and emotional maturity (developmental capacity to understand and interpret the maltreatment); and
- physical and psychosexual developmental level of the child.

This section will present a brief summary of intrapersonal and interpersonal problems reported in the literature about maltreated children—and issues that adults abused as children experience. Each form of maltreatment is presented separately; however, it is important to emphasize that neglect and emotional, physical, and sexual abuse can overlap in families.

PHYSICAL ABUSE

The consequences of physical abuse on the developing child have been well documented. Salter, Richardson, and Kairys state, "Abused children have learned that their world is an unpredictable, often hurtful place. The adults who care for them may be angry, impatient, depressed, and distant. Further, they can be transformed without warning, into hostile, violent persons."[8] With a physically abusive parent, the child's attachment is affected in a manner that causes the young child to develop a perception of himself as incompetent, unloved, and unlovable. This experience can result in a pattern of expecting the infliction of pain or injury from others, of behaving in ways to incite pain and injury, of distrusting closeness, of feeling helpless and powerless, and of developing wariness or suspicion of others.

Older children often demonstrate some type of affective problem (e.g., depression, sadness, anxiety). They numb themselves to abuse, become limited in their ability to perceive their own feelings, and have difficulty interpreting and responding to the emotional expressions of others. As a result of abuse, children and adults may develop a pattern of denying or limiting certain emotional responses (i.e., feelings that may be conflictual) which, in turn, limit their ability to be expressive or spontaneous in other contexts. Although this blunted affective ability and response may be useful in coping with the psychic pain of being abused, it may inhibit the range of emotional responses and impairs an important part of a child's development.

Older physically abused children also have a tendency to become caretakers for their abusive parents.[9] These children often engage in caregiving actions that serve to meet the needs of their parents and reduce parents' stress. The children may also provide similar caregiving behavior to younger children within the family to provide assistance to their parents, meet the needs of the siblings, and reduce stress within the family. A further explanation of this caregiver role reversal is the need to counteract feelings of powerlessness and acquire positive meaning and appreciation within their life as a way of maintaining closeness to their attachment figure.

Both verbally and physically aggressive behavior and passive compliance and avoidant behavior have been reported by studies investigating physically abused children. Green suggests that aggressiveness is an effort by abused children to avoid feelings of helplessness and anxiety.[10] Helfer suggests that being raised in an environment where physical abuse is a common response to problems, feelings, and conflicts impairs several important developmental behaviors such as problem solving, accepting delayed gratification, and impulse control.[11] Without the opportunity to learn these behaviors, a child responds in ways that are modeled within

the family. In response to conflict, negative affect, or a problem, abused children resort to some type of verbal or physical hostility or passive compliance to resolve the problem or to meet their unmet needs.

Physically abused children frequently have significant problems in their ability to develop and sustain peer relationships. In their review, Mueller and Silverman state that "the very heart of peer relations, a felt equality between partners, involves developing a working model of relationships that is based on sharing, equality, and non-exploitation. The experiences of abuse and neglect seem antithetical to developing such a model."[12]

SEXUAL ABUSE

In reviewing the empirical research on child sexual victimization, some type of intrapersonal disturbance in children, adolescents, and adults has been consistently reported. A sexual abuse victim feels a sense of shame unlike that from other forms of abuse. Even the youngest children drop their voices to barely audible during interviews when describing the details of sexual abuse. The shame is in response to both the misuse of the child and the abuse of the sexuality that is both a physical and psychological aspect of human beings.

Sexual abuse victims experience a loss of power and control over their lives. They report symptoms of fear, anxiety, isolation, vulnerability, feeling different from others, and feelings of low self-esteem. With intrafamilial abuse, they also feel a sense of betrayal toward the abusive parent, grandparent, or sibling and anger toward the nonabusive parent if they failed to believe or protect them. Porter, Block, and Sgroi describe sexual abuse victims perceiving themselves as "damaged goods," a characterization to describe an overall sense of poor self-image.[13]

Finkelhor describes the dynamic of betrayal as shown through distrust in others[14 15] and conflicted relationships with others as shown through reactions of fear and hostility.[16 17] Despite this sense of distrust or wariness towards others, research regarding victims of sexual abuse has shown that they have an increased risk of being revictimized.[18]

A consistent finding in research describing consequences of child sexual abuse is the increase in sexualized behavior in many children and promiscuity in adolescents and adults. Two studies using standardized measures of assessment have indicated that sexually abused children tend to be more involved with sexual ideation and behavior.[19 20] One study reported that nearly three-fourths of the boys and slightly more than two-fifths of the girls exhibited some type of sexual problem (e.g., preoccupation with masturbating, masturbating in public, talks about sex too much).[21] In a second study, approximately one-fourth of the younger age group (4–6 years) and one-third of the older age group (7–13 years) were elevated on a sexual behavior scale (which included items about excessive sexual curiosity, open masturbation).[22] In a smaller sample of 14 boys referred to therapy for sexual aggression, Friedrich and Leucke identified 11 of them with a history of being sexually victimized.[23] Several clinical case studies report a variety of sexual behavior problems in children with a history of sexual abuse, including problems with sexual acting-out, an exaggerated interest in sexuality, and an increased interest in sexual material.[24 25 26] Finally, several researchers have suggested that having a history of sexual abuse may contribute to becoming a sexual offender (either as a juvenile, adult, or both).[27 28] It is important to note that, as a group, sex offenders may possess a relatively high prevalence of child sexual abuse in their childhoods, but this does not mean that children who have been sexually abused will become sexual offenders.

An extensive study conducted by the Tufts' New England Medical Center, was one of the first research reports to use standardized measures in examining sexually abused boys and girls.[29] This study reported that nearly half of the oldest age group (7–13 years of age) showed substantially elevated levels of hostility on scales of aggression and antisocial behavior on the Louisville Behavior Checklist. Similarly, approximately one-sixth

of the younger age group (4–6 years of age) were reported as being elevated on these same scales of aggression and antisocial behavior.

NEGLECT

In neglectful families, the infant or child does not experience an actively involved, caring, responsible, and reliable caretaker. These children do not experience recognition of themselves or their needs. The consequences of this experience for overall personality development are profound. In contrast to physical and sexual abuse (where children experience visibility, albeit negative) with neglect, the child feels invisible.

This childhood experience may manifest in symptoms of withdrawal, depression, passivity, and disorientation or confusion. Neglected children have been shown to become helpless and passive, and they tend to roam aimlessly when placed in a situation where they are temporarily separated from their parent.[30] Howes and Espinoza report that the neglected children appeared to display less affect, either positive or negative, in their peer encounters.[31] Helfer reports that being raised in such an abnormal environment results in several intrapersonal problems because the child's needs are not consistently met. Core self-esteem is pervasively damaged.[32] The processes of decisionmaking and problem solving are rarely modeled adequately, and the child has limited opportunity to build and practice these skills. Some of these children do not fully develop the capacity to control their feelings and actions or develop delayed gratification, which results in impulsive behavior.

It has been reported that many neglectful mothers have difficulty providing adequate care for their children because of their past history of maltreatment.[33] As a result of dysfunctional interpersonal relationships, these mothers have difficulty coping with the demands of an intimate relationship and may not understand their children's cues and interactions because of their own emotional limits and instability. They may have limited capacity to engage in healthy attachment relationships with their children. Consequently, their children may never acquire the basic interpersonal skills and may grow up to perpetuate this intergenerational transmission of relationship dysfunction.

When interacting with peers, neglected children tend to be withdrawn from schoolmates or relate to peers in a disorganized, active, or aggressive manner. They may exhibit fewer positive play behaviors, such as offering, sharing, showing, accepting, throwing, and following. This problem in peer relationships is supported by Hoffman-Plotkin and Twentyman,[34] who report that neglected children tend to be more withdrawn than physically abused children and nonmaltreated children. Additionally, their research suggests that both physically abused and neglected children exhibit less prosocial behavior than nonmaltreated children. This is consistent with another study, which reports that neglected children directed fewer positive behaviors toward their peers, initiated fewer interactions, and were involved in simpler forms of play.[35] In a related study, it was found that neglected children appeared resistant to approaches from a friendly playmate, confirming the researchers' assumption of problems related to prosocial abilities.[36]

MENTAL HEALTH EVALUATIONS

Children and parents may be referred for evaluations for legal or forensic purposes or for case planning and treatment purposes. Clarifying the reasons for the evaluation referral is important. The mental health professional needs to identify the questions that need to be answered by this evaluation and the purposes for which this information will be used. Professionals from the fields of criminal justice and CPS making referrals may need information about mental health evaluations, what questions can be answered, the different objectives of forensic and clinical assessments, psychological testing, and consultation on how to interpret the results of psychological assessments. Mental health professionals must also understand the difference

between forensic and clinical evaluations, clearly explain their role to the client(s), and clarify for clients such issues as client confidentiality and release of information as they relate to each type of evaluation.

FORENSIC EVALUATIONS

Children are referred for evaluations by law enforcement investigators, attorneys for the defense or prosecution, or by CPS for help in determining whether abuse occurred. Sexually abused children are most commonly referred for this reason because the case is often entirely based on statements made by the child, and it has been determined that a specially trained clinician is needed to perform the interview. Physical findings from medical/evidentiary exams, which can support the case, are only present in about 28 percent of the cases.[37] This is in contrast to physical abuse and neglect cases, in which the case is largely based on the physical evidence.

Because child sexual abuse cases are mainly based on children's reports of what happened, children are frequently subjected to multiple interviews by multiple interviewers. The purposes of these various interviews are to obtain information for criminal investigations and make child protective custody decisions. Multiple interviews by multiple interviewers have been found to be emotionally damaging to children.

Multidisciplinary interview centers are beginning to be established in some communities to reduce this trauma to children. At these sites, specially trained specialists conduct interviews that meet the needs of both criminal and CPS investigations. Law enforcement investigators, CPS social workers, and prosecutors observe the interviews behind a one-way glass. The interviews are also videotaped to reduce the need for repeated interviews.

Because many communities have not yet established this practice, it is not uncommon for mental health professionals to receive referrals for forensic evaluations of children. Other reasons for these referrals are: the child shows behavioral symptoms of being sexually abused, but will not make any verbal statements; allegations in divorce/child custody disputes include abuse or neglect; confusion or conflict exists in the case, and an independent professional is needed to sort out the issues; and, recently, in physical abuse cases, mental health professionals have been called on to testify on "battered child syndrome" as a defense for homicide. These are cases in which adolescents have murdered their parents after years of physical and emotional abuse. Since nearly all of these types of evaluations require submitting a report to the court and testifying, mental health professionals must be prepared to defend their conclusions and recommendations, their education and credentials, and their knowledge of the literature.

The primary purposes of the forensic evaluation are to determine if there is sufficient information to file charges related to child maltreatment and if the child is sufficiently capable of providing valid and reliable information. Typically, this involves determining the child's ability to recall information (i.e., developmental, intellectual, and affective functioning), acquiring basic information about the complaint, and documenting psychological and behavioral symptoms associated with abuse that support the allegation. This type of assessment requires knowledge of child development to enable the clinician to understand the abilities of a child to recall information at various ages, how to approach and interview children, and how to interpret the information provided by the child. A pitfall to avoid in interviewing young children for legal purposes is to ask leading questions that suggest the answer. Training with law enforcement investigators is recommended to distinguish between an appropriate question and a leading question that suggests or promotes an answer. Videotaping interviews may be helpful to preserve the child's answers to questions and document the manner in which they were asked. The following format can be used in these evaluations:

- **Identifying information about the victim**: Name, address, phone number, age, birth date, school information (grade, teacher's name), etc.

- **Information about the victim's family**: Family size and membership, sibling ages, occupation(s) of parent(s) or means of financial support, description of other people living in the home, and description of all persons responsible for the child's care.

- **Descriptive information about the type and frequency of the offense**: Specific information about what occurred, when, how often, duration (weeks, months, or years), events that occurred just prior to and after the abuse, and whether siblings or other children were abused. For sexual abuse cases, it is also important to ask if photographs were taken or if videotapes were made.

- **Identifying information about the suspected perpetrator(s)**: Name, address, age, relationship to the victim (e.g., parent, friend, babysitter, relative), and whether there were one or more suspected perpetrators. In families with multiple male spouse/partners, it is important to distinguish between "Daddy John" or "Daddy Mike" to avoid implicating the wrong person.

- **Acquisition of information about any witnesses to the abuse/neglect**: Identification of other people who might have observed or participated in the abuse, been involved as additional victims, and/or who might have important information about the abuse/neglect, etc.

- **Documentation of psychological reactions and behavioral symptoms**: While psychological reactions and behavioral symptoms can be documented to support the allegation(s), symptoms alone, without other evidence, are usually not acceptable for investigative agencies to substantiate that abuse/neglect occurred.

Parents

Evaluations are performed of both abusive parents and nonoffending parents. The purpose of the evaluation of abusive parents is to assess their mental status; the presence of personality disorders, psychiatric problems, or psychopathology; character strengths and weaknesses; the precipitant of the abuse/neglect and whether the precipitants are chronic or situational; whether the person has a substance abuse problem; whether the parent admits or denies the abuse/neglect and can acknowledge the emotional or physical consequences to the child; whether the parent is amenable to treatment; the type of treatment recommended; whether incarceration is recommended; and the presence or absence of supportive family and friends.

The purpose of the evaluation of nonabusive parents includes all of the issues listed above with the exception of recommendations for incarceration. The main focus of this evaluation is the nonabusive parent's ability to protect the child given the presence of any mental health, characterological, or substance abuse problems. This evaluation extends to the nonabusive parent's relationship to the abusive parent from the standpoint of whether they are intimidated by or dependent on the abuser and whether they are able and willing to protect the child and comply with court orders.

CLINICAL EVALUATIONS OF CHILDREN, PARENTS, AND FAMILIES

The purpose of the clinical evaluation is to assess the nature and extent of the presenting problem(s), the client's current level of functioning, the client's capabilities of improved functioning, and the client's willingness and motivation to participate in treatment. The primary objectives of the clinical evaluation are as follows:

- Assess psychological and behavioral symptoms of client(s): Evaluate the presence of psychological and behavioral symptoms; the level of stress and stress factors; the client's perception of himself; how

the client reports relating to others; the level of support from family and friends; and somatic symptoms such as appetite or sleep disturbances, anxiety, post-traumatic stress symptoms, phobias, and the possibility of substance abuse problems.

- Identify the existing relative strengths of the client(s): Assess the client's intellectual functioning, social skills, peer relationships, family relationships, emotional stability, adaptations and maladaptations, and the perception of the situation—especially attributions of responsibility (self or others)—and defense mechanisms. Assess the client across domains, such as school or work, to further identify strengths in functioning and determine whether adaptive strengths are found in all areas.

- Identify the existing relative weaknesses of the client(s): Assess the existence or potential of mental health problems, maladaptive behavior traits or disorders, the tendency to internalize or externalize behavior, attributions of responsibility, and defense mechanisms. Assess the client across domains such as school or work to further identify problems in functioning or whether maladaptive traits carry over to all areas.

- Determine the capabilities and availability of supportive resources: Assess the degree of the child's and parent's isolation, their ability to obtain and receive support, the corresponding capability and availability of the support system, and the degree of family (both nuclear and extended) cohesiveness.

- Assess the need for a medical, psychiatric, or psychological evaluation: Inquire about medical problems, psychiatric history, or symptomatology.

- Target and prioritize symptoms or behaviors that may be particularly harmful to the child or others (e.g., suicidal ideation, revictimization, or aggressive behavior toward others): Assess the risk of suicide for both the child and the parents; the potential of revictimization of the child; the potential of the child to act out sexually or physically toward other children; the potential of parent's aggressive, hostile, or impulsive behavior; and the potential of high-risk behavior. (Additional information on assessing risk for suicide is presented later in this chapter.)

- For children, assess for symptoms across areas of functioning and degree of parental support: Assess for symptoms expressed by the child at home by interviewing parents or foster parents and at school by talking to teachers. Establish a mental health treatment history, if indicated, from past therapists. Assess the level of parental support and risk of withdrawal of support due to diverse parental reactions to disclosure of maltreatment.

- Assess the motivation for treatment: Families may voluntarily seek treatment because one or more family members are engaging in behavior that makes the family system unworkable or that causes undue stressors. Parents may be court-ordered to participate in therapy to retain custody of their children, to acquire custody of a previously maltreated child currently in foster care (family reunification), to comply with sentencing requirements, or as an alternative to incarceration (diversion programs). It is important for mental health professionals to understand both the reasons for their client/family to be involved in therapy and their motivation for change.

Assessing Suicidal Risk

Although suicidal ideation and attempts are less frequent with children than adults, a consistent number of children attempt suicide. According to the National Center on Health Statistics, the nationwide suicide rate among teenagers in 1983 was 8.7 per 100,000.[38] Pfeffer provides a description of the demographic variables related to suicidal children.[39] She states that suicidal ideation and attempts are far more frequent among boys than girls and that it is a much more frequent problem for teenage children than for younger children. There may be several reasons or motivations perceived by the child that lead to suicidal behavior. These include impulsive responses to aggressive or hostile situations; the influence of guilt and remorse; manipulation and punishment of the parents (i.e., "You'll be sorry when I'm dead"); or the need to join a deceased relative, decrease or end a sense of loneliness, or seek a solution or end to an unbearable situation.

Behavioral Cues to Suicide

- Change in behavior patterns (e.g., increased withdrawal or isolation, giving away prized possessions).
- Multiple physical complaints, symptom increase, or frequency of depression (e.g., insomnia, weight loss, slowed or agitated behavior, fatigue, loss of energy, self-reproach or guilt, decreased concentration and decisionmaking ability, recurrent death thoughts or wishes, loss of pleasure, loss of interest, and sadness).
- Suicide attempts or thoughts (e.g., dangerous, self-destructive behavior, overdoses of pills, ingestion of poison, frequent accidents).
- Suicidal risk increases with inadequate resources of social network (e.g., has no one to talk to when feeling bad, has no one to ask for help, has unclear idea of when to get help, and has no supportive relationships).

MENTAL HEALTH TREATMENT ISSUES AND MODELS

Professionals providing mental health services to children must have a solid foundation in the stages of normal child development and how child maltreatment can adversely affect children's development and behavior.

INTRAFAMILIAL CHILD SEXUAL ABUSE TREATMENT

Two important caveats must be presented before discussing therapeutic issues in incestuous families. The first is that insufficient empirical research has been conducted on the effectiveness of interventions with incestuous families, particularly with sexual offenders who are at high risk for recidivism. Second, existing research suggests that incestuous families are a very homogeneous group. There may be many different types of incestuous families that have not yet been identified and grouped at this stage in our knowledge. Regardless of whether different subtypes exist, common themes or patterns of behavior have been identified in the clinical literature.

Isolation

One of the more common features of incestuous families is the degree to which they are closed off and outside the normal socialization processes that naturally occur with families. This isolation may be the result of poor or underdeveloped social skills on the part of the parents or the family's general avoidance of activities that require them to function in interpersonal relationships. Isolation may also enable perpetrators/fathers to have more control over the family and engage in their abusive behavior within an environment that has a lower risk of disclosure. Alexander suggests that isolation also serves to prevent exposure of family members to healthy, appropriate family models of functioning.[40]

Poor Communication and Ambiguous Boundaries

Within healthy families, one of the important characteristics of family functioning and the development of individuals within the family is communication and the development of specific roles and boundaries within the family. Incestuous families are characterized by limited intrafamily communication such as keeping secrets and not discussing abuse-related behavior and feelings. Family members are not likely to discuss topics such as sexuality, the limits of physical affection, acceptable behavior between siblings, and questionable parental behavior. Incestuous families are also characterized by blurred interpersonal boundaries. Without a clear understanding of the roles and responsibilities of family members (especially between parents and their children), these issues may become ambiguous and more accessible to sexual manipulations.

Sexual Distortions

Sexual abuse research has consistently reported an intergenerational component associated with child sexual abuse. That is, many children who have been sexually abused may also have one or both parents with a history of sexual victimization in their childhoods. As Finkelhor and Browne point out, one of the common sequelae of child sexual abuse is a pattern of sexual distortions (i.e., traumatic sexualization).[41] This pattern results in confusion about sexual identity and sexual norms, confusion between sex and caregiving, aversions

to sex or intimacy, and the conditioning of sexual activity with negative emotions. Parents who were sexually abused as children may have developed distorted images and values about sexuality, which they in turn transmit to their children and partner. Lack of information and confusion about sexuality, including sexual boundaries and limits, and distortions about sexual roles and relationships may foster the development and acceptance within the family of incestuous behavior.

Intervention Issues

Some key intervention issues in incestuous families include:

Assessment of the Child's Immediate and Long-Term Treatment Needs

Children may need crisis intervention if the disclosure has just occurred, investigative agencies have just become involved, and a medical examination is required. The trauma of disclosure should not be underestimated, even if the abuse has been taking place over a period of time or occurred long ago. The assessment should include the need for crisis intervention, brief therapy, or long-term therapy to resolve victimization issues.

Child's Safety from Abuse

As a prerequisite for any type of family therapy or effort to reunify the incestuous family, there must be a focus on the safety of the child, the right of the child to be free from abuse, and the capability of the nonoffending parent to maintain a protective attitude toward the child. Recantation of the sexual abuse allegation by the child can distract professionals from the safety issue. It should not be assumed that because a child recants, the abuse did not happen. Possible reasons for a child recanting include nonsupport or withdrawal of support by the nonoffending parent; pressure by the nonoffending parent, siblings, grandparents, and other relatives to deny previous statements; the child's compassion and need to protect and defend his/her parent; the child's removal from the home and desire to return home under any circumstances; poor intervention and management of the case by investigative agencies; and fear of going to court and testifying.

Empowerment of the Nonoffending Parent

In many incestuous families the nonoffending parent (typically the mother) is often described as passive, dependent, and nonsupportive of the child. Some mothers may be initially supportive and later withdraw support from the child. Nonsupport by the mother may cause the child to recant his/her report. Supportive interventions are needed to help the mother support the child and establish herself apart from the often dominant partner/spouse. The mother's support may be because of coping style (denial, distancing), prior victimization history, attachment history with her parents and subsequent relationship with her child, emotional distress, mental health/health problems, poor social support, substance abuse, and situational factors related to disclosure of sexual victimization such as criminal and dependency investigations, court appearances, and the breakup of the family structure (e.g., displacement and separation from the partner/spouse, the financial stress of independent living, and the increased responsibilities of a single parent).

Management of Sexualized Behavior

One of the most common symptoms and concerns associated with child sexual abuse is the premature exposure and expression of inappropriate sexual ideas and behaviors. It may be necessary for the mental health professional to provide sex education to both the child victim and the parents, while supporting the parents' open discussion of appropriate sexuality, sexual feelings, and guidance about sexual behaviors.

Skill Building and Education

One of the components of treatment must involve breaking down the walls of isolation surrounding incestuous families by developing social and communication skills, building self-confidence, providing assertiveness training, strengthening abilities to identify limits and set boundaries, developing a sense of entitlement, and promoting involvement in extrafamilial activities such as parent groups and school or community organizations. The mental health professional may also need to be a primary source of information and education about child development, sexuality, family values, parenting, and discipline.

Status of the Intrafamilial Perpetrator

Mental health professionals making treatment plans for children and families in which intrafamilial sexual abuse occurred must know the legal status of the perpetrator (biological father or stepfather). There are at least seven possibilities: (1) the case is pending, the alleged perpetrator is in or out of the home, and the child is in or out of the home depending on the status of the alleged perpetrator; (2) the perpetrator is incarcerated, and the mother is not interested in reunification; (3) the perpetrator is incarcerated, and both parents plan to reunify after release; (4) the perpetrator receives a prison sentence that includes post-release participation in treatment as a condition of probation; (5) the perpetrator is sentenced to weekends or nights in the county jail with participation in treatment as a condition of weekday release; (6) the perpetrator participates in a locally approved diversion program and receives treatment in lieu of incarceration; or (7) there is insufficient evidence to prosecute the case but sufficient evidence for child protective services involvement, and the alleged perpetrator seeks treatment as a condition of family reunification. The following is a brief summary of four issues to consider in providing mental health services if there is a possibility that the perpetrator will reunify with the family.

Willingness of the Perpetrator to Assume Genuine Responsibility

The principal defense mechanisms employed by sexual offenders are denial ("I didn't do it"), minimalization ("Everyone is making an issue out of this... I only..., It was only..."), and rationalization ("She wanted me to touch her"). Sexual offenders are often highly manipulative individuals and may even see limits as a challenge. Therapists need to be alert and adept at limit setting and must anticipate surface compliance and undermining behavior. Genuine acknowledgment and assumption of complete responsibility for the sexual abuse is the starting point for intervention and the eventual reestablishment of family relationships. The perpetrator needs to demonstrate that he understands and recognizes what he has done, understands the pain he has brought to the child, and desires to have a different, more healthy relationship with the child. This message may need to be communicated several times and in many different ways, and it is also important that the perpetrator demonstrate his commitment to a nonabusive relationship through actions and behaviors (e.g., being responsive to the needs of other family members, participating in ongoing therapy).

Awareness and Management of Incestuous Thoughts and Behavior

One of the hallmarks of the treatment of sexual perpetrators is the acknowledgment and disclosure of sexual interest in children. As Ryan suggests, the development of sexual interest in children is not impulsive but the gradual shifting of distorted or inappropriate thoughts to behaviors.[42] Perpetrators must learn to be aware of both their sexual urges toward children and the thoughts or actions that may lead to inappropriate sexual activities. Behavior modification, anger management, stress reduction, and relapse prevention are essential therapeutic strategies.

Highly specialized sexual offender treatment programs have been developed for adults, adolescents, and young children. Pioneering programs for adult sexual offenders first began in the 1950's. Research and

treatment programs expanded to include adolescents by the early 1980's. By 1984, the need became apparent to develop programs for children between the ages of 4 to 13 who sexually abuse other children. "Abuse-reactive behavior" is the term now used to describe sexual acting-out behavior of young children who have been sexually abused and now victimize other children.[43]

Marital Therapy

Within the reunifying incestuous family, it is important to reestablish the marital partners as a coalition that works together to meet the needs of the family and protect the child. In those instances in which the marital relationship is viable and the parents wish to continue their marriage, it is important to address marital conflicts and patterns of relationships that may be unbalanced or oppressive. Issues such as marital communication and power distribution within the couple on issues such as conflict resolution, decisionmaking, and sexuality may need to be explored.

Reestablishment of the Parent–Child Relationship

Before reestablishing a parental relationship with his child, the sexual offender must address several fundamental issues with both his spouse and his child. These issues include an examination of trust, betrayal, and a commitment to the well-being of the child; distinctions between physical affection and sexual behavior; assignment of responsibility for the sexual abuse; open expression of affect within the family; and well-defined expectations of sexuality and sexual behavior. Related to this issue are arranged confrontations between perpetrator and child by therapists. This is a controversial issue among experienced clinicians and should not be considered without reviewing the literature and discussing the ramifications with experts.

The Comprehensive Sexual Abuse Treatment Program (CSATP)

The first prominent model for treating incestuous families was developed by Henry Giaretto, Ph.D., in the mid-1970's and is now called the "Giaretto Model" or Parents United. In response to an absence of treatment approaches to deal with incestuous families, Giaretto developed the Comprehensive Sexual Abuse Treatment Program (CSATP), which consists of:

- individual counseling (child, mother, father);
- mother–daughter or mother–son counseling;
- marital counseling;
- father–daughter or father–son counseling;
- family counseling;
- group counseling for nonoffending mothers and fathers, offending mothers and fathers, couples, girls, boys, and nonvictimized siblings; and
- a self-help group component (e.g., Parents United, Daughters and Sons United).

CSATP has been a well-established model for over 15 years with city, State, and international chapters. Variations of this model have developed over the years; however, the organizing theme of every program is the development of a comprehensive and coordinated approach designed to meet the needs of all of the family

members. Local programs' philosophies regarding incarceration and treatment services for the perpetrator are the most frequent reason for the variation in approach.

Nonfamilial Child Sexual Abuse: Providing Support To Parents

One of the most significant factors in the sexually abused child's adjustment is the level of emotional support from his/her parents.[44 45] Parents need specific information on how to support and provide assistance to their child, how to discuss the incident and future safety precautions, how to respond to the child's questions and feelings, and how to talk to the child's siblings about what happened. Parents may also need to be educated about the importance of respecting children's privacy by telling only selected family members or friends after disclosure to investigative agencies, and prevent inappropriate people from questioning the child about what happened. They also need information about how to anticipate the range and changeability of their own feelings from anger, rage, guilt, and confusion to anguish, disbelief, and blame. They may need counseling to address their own feelings to avoid creating tension, stress, shame, or guilt in their child. Parents may need to discuss feelings of self-blame and recrimination for what occurred, if they blame themselves, or they may need information about the need for parental supervision and selection of appropriate caretakers, if they have been careless.

Child Physical Abuse Treatment Components

During the last decade, there has been a growing awareness of the multifaceted stress factors that contribute to the physically abusive family. Risk factors include:

- environmental stressors such as unemployment, financial problems, poor or inadequate housing, or lack of transportation;
- parental interpersonal stressors such as marital discord, single parenting, imbalanced relationship with marital partner (dominant or noninvolved), past history of abuse, isolation, or inadequate social and familial support;
- intrapersonal problems such as low self-esteem, low sense of self-competence, poor self-control, poor interpersonal skills, poor communication skills, poor problem-solving skills, anxiety, depression, or substance abuse;
- poor parenting skills (rigid, authoritarian, or poor limit setting), with little knowledge about child development and current child rearing practices; and
- child with behavioral problems or special needs that cause stress, such as developmental delay, chronic illness, or physical disability.

Walker, Bonner, and Kaufman have developed a systematic Physical Abuse Assessment Model and a Physical Abuse Process Therapy Worksheet that addresses the range of risk factors listed above through complete problem identification, problem and strength assessment, planned interventions which correspond to identified problems, and planned use of client strengths.[46]

Recommended interventions include individual, group, and marital counseling, and parenting education classes with a curriculum that includes anger management and impulse control, stress reduction, increasing self-esteem and coping skills, and child management skills. Some programs and communities also offer parental stress toll-free telephone lines and respite care centers to provide information and relief for parents

experiencing stress or other overwhelming situations. The primary focus of many programs is to provide services to the parents. There has been little focus in the clinical literature regarding treatment for severely or chronically physically abused children, including burn victims with disfiguring injury.

There are two key intervention issues for abusive parents:

Education and Skill Training May Not Be Enough

Several research groups point out that education and skill training alone are not enough to remedy child maltreatment.[47] [48] [49] They stress the relationship between a defective self-image and a reduced ability to cope with crisis and stress. The ability to cope is related to positive cognitive appraisals of oneself, adequate social supports, and knowledge and skills. Nurius, Lovell, and Edgar found that abusing mothers on a self-concept appraisal scale tended to view themselves in one-dimensional, fixed ways (e.g., "It's just my nature" "I guess you are who you are and that's it") and with negative self-attributes such as being impatient, ineffective, and out of control.[50] These authors recommend that detailed attention to self-appraisal be part of the assessment process prior to treatment and that building positive self-appraisal is a critical step to increasing the parent's ability to cope with stress and remain in control.

Aggression Management

Wolfe reports that establishing inhibitory controls for aggressive behavior such as relaxation and stress management is a key factor in treatment for abusive parents.[51] His associates found evidence of greater levels of physiological arousal in the face of child-related stress among abusive parents than in non-abusive parents.[52] Since emotional arousal facilitates the development of aggression, this may suggest that parents' emotional arousal may contribute to a physical assault on their children.[53] Abusive parents participating in a 13-week treatment program reported significant changes in their interactions with their children. The treatment program adopted the multimethod approach recommended by Novaro,[54] which included anger management training to reduce physiological arousal; training in communication skills and problem-solving skills to improve interpersonal and parenting skills; and training in developing an empathic response to children by enabling parents to see the child's perspective, to see the child as an individual and not an extension of themselves, and to accurately interpret the child's intentions.

Self-Help Groups

Self-help groups first emerged in the United States in the 1920's, the best-known examples of which are Alcoholics Anonymous and Gamblers Anonymous. The first self-help group for abusive parents, Parents Anonymous, was established in 1970 by a mother, Jolly K., who found that traditional psychotherapy was not enough to deal with her abusive tendencies. After that first group was formed, Jolly K. and the Parents Anonymous model's co-founder, Leonard Lieber, L.C.S.W., went on to develop groups and chapters throughout the United States as well as worldwide.

In general, self-help groups comprise individuals with a common experience or problem that they are trying to resolve, recover from, or handle in new and constructive ways. These groups can be described as having one of two goals: to bring about a change in behavior or to enable members to constructively adapt to life experiences or change. The first type of group focuses on the need to modify or control members' attitudes, behaviors, and effects on others. These organizations provide intensive support systems that reinforce the importance of the members' behavior change. The second type of self-help group focuses more on adaptation and coping through internal attitudinal, behavioral, or affective changes. The goal of these groups is adaptation to major life changes or events such as death, catastrophic accidents or illness, or victimization experiences.

Parents Anonymous Model

Parents Anonymous has chapters in many communities that provide groups for parents and treatment groups for children to reduce and prevent child abuse. The Parents Anonymous model works best for parents who are more "explosive" in their behavior or those who have physical and verbal or emotional abuse problems.

This model operates support groups, at no charge to members, that have a volunteer professional sponsor with expertise in the provision of psychological or social services. The sponsor is involved as a group consultant and as a resource for the parent–chairperson who leads the group. An important role of the sponsor is to function as a positive authority figure. In this role, the sponsor can identify and refer members who need additional services such as individual therapy or family counseling. The sponsor also serves as a role model or positive authority figure for members who have abusive experiences with caretakers. In this capacity, the sponsor can facilitate the resolution of individuals' reactions toward past authority figures and learn to incorporate new ways of being positive authority figures in their children's lives. Several factors have been identified as the reasons for the success of self-help groups in modifying behavior:

- **Universality or Instant Identity**: This describes the importance of being part of a group that shares a common condition and understands each others' experience. Universality is considered the key to the self-help experience because it reduces the person's sense of isolation, of being "different," or of having a unique problem, and it opens the possibility for change.

- **Altruism**: Helping others in the group is one of the guiding principles of many self-help groups because it increases members' self-esteem.

- **Belief System or Set of Assumptions**: This refers to an ideology, a belief system, or a set of assumptions about human life and functioning that reframes the negative experience and enables the individual to adapt and live effectively. Paul Antze has described this ideology as a "cognitive antidote."[55]

- **Network of Peers**: This refers to the intensive support system that includes group meetings but extends to support provided outside the group through the telephone and/or home visits.

- **Hope**: Another important principle is the emphasis on hope–adopting a positive philosophy about taking one day at a time and assuming that life will get better.

- **Information**: Sharing information from research and publications and from personal experience helps members to change and adapt.[56]

NEGLECTING FAMILIES: INTENSIVE IN-HOME INTERVENTIONS

Intensive, in-home therapeutic counseling and social services have been found to be most effective with neglecting families. The primary goals of these services are to improve parents' abilities to raise their children in a healthy environment, keep families intact through supportive services, and reduce the risk of an out-of-home placement for children. These services are designed to improve family coping skills and functioning, provide emotional support to parents, model problem solving to cope with everyday problems and parent–child interactions, promote positive parenting skills and optimal child development, and teach household management skills, including nutrition and financial management. The programs' "parent the parent" strategy allows initial dependence before encouraging independence. "Do for, do with, cheer on" describes the philosophy and approach of these programs.

These types of programs may be called by a variety of names, including "Family Preservation," "Homebuilders," "Family-Centered Services," "Home-Based Services," "Intensive Family-Based Services," and "Home-Based Treatment." The general characteristics and features of these programs include:

- Families at risk of their child being placed out-of-home are the target population served, and the intake and assessment process ensures that the child is not in danger while remaining in the home.

- Services are crisis oriented and intensive, usually from 3 to 6 weeks or longer depending on the program.

- Services provide a combination of teaching skills and counseling to each family member and to the family as a whole. Emphasis is placed on assisting both the child and parents to understand how the family functions as a whole.

- Workers see families within the homes of their clients, make frequent visits, and visit at times that are convenient to the family. Workers may also be actively involved in providing services through school and neighborhood agencies/settings.

Each worker carries a small caseload—from one to three families at any given time. A general perspective of family preservation programs is to work with family strengths and include the use of the extended family, community, and neighborhood resources.[57] Numerous theoretical approaches have been described as being part of family preservation services including crisis intervention theory, family systems theory, and social learning theory.[58]

TREATMENT MODALITIES

The process of determining the most appropriate type of intervention is based on the mental health professional's assessment of the child, parents, and family. The organization and delivery of treatment services are also affected by public funding of mental health clinics and treatment services, health insurance benefits, access to health insurance, and eligibility for treatment under Victims of Crime Programs. Some considerations for individual therapy include:

- **Child characteristics**: Age, verbal ability, emotional maturity, presence of a developmental disability, social skill level, and the impact of the problems on the child's social adjustment.

- **Parental characteristics**: Emotional immaturity, concrete thinking versus insight–oriented individuals, motivation, or the presence of a developmental disability.

- **Nature of the presenting problem**: Mental health issues (e.g., depression, schizophrenia, anxiety disorder; personality disorder; substance abuse), self-esteem issues, sexualized behavior, enuresis, or urgency of intervention required (e.g. suicidal or self-destructive problems).

- **The lack of organization of the family**: Whether parents are able to appear for scheduled appointments at an office. For example, many families may not have the finances and/or ability to come to therapy on a weekly basis. In such cases, alternative interventions, such as intensive home-based services have proven most effective with neglecting families or chaotic, disorganized families.

Indications for family therapy include:

- **Dynamics of family communication and family interpersonal relationships**: Whether the family should be seen together or in dyads to improve relationships. Family therapy is helpful in addressing family system dynamics, communication problems, imbalanced relationships, feelings of abandonment or distrust, or problems in the expression of emotion.

- **Low level or no support for the child**: Acknowledgment that the child has been victimized, belief in the child's reports of abuse/disclosure, or blame placed on the child.

- **The presence of behavioral problems or symptoms with siblings**: Involves siblings who may also have been physically and/or sexually abused and may have parallel issues which need to be addressed within a family setting.

- **Child's age**: Addressing the problems of young children typically requires significant parental involvement, whereas older children (e.g., teenagers) are more able to benefit from individual or group therapy approaches.

Indications for group therapy include:

- An assessment that the client would benefit from being part of a group that shares a common condition and can understand one anothers' experience. This experience, often referred to as "universality," reduces isolation and the sense of being "different." Participation in a group also enables the client to interact with group members who have resolved some issues and "moved on" as well as with others who are struggling with issues the client may have mastered, thereby enabling the client to lend insight and support to others.

- A group therapy approach is typically not recommended for a child's first encounter with therapy for child sexual abuse, physical abuse, and/or neglect. Many of the issues that children initally encounter in dealing with their victimization are too personal, embarrassing, and painful to disclose and discuss within a group therapy setting. Group therapy is usually indicated for children who have first been involved in either individual or family therapy and have addressed many common abuse-related issues (e.g., distrust, betrayal, problems with self-esteem, stigmatization).[59]

- Age and development are important considerations for selecting a group therapy approach. Children with poorly developed expressive and receptive language skills may have difficulty with a group therapy format. Similarly, many of the essential elements of "attending" within a group are not adequately developed until at least the preschool years. Very young children may not be able to verbally facilitate and process much victimization information and affect. A group therapy approach to dealing with victimization issues is more appropriate for school-age children and teenagers.

- Group therapy may be particularly helpful for children and adolescents who need assistance in seeking validation and support. The process of disclosing victimization experiences and feelings may alleviate children's perceptions of themselves as different, stigmatized, and "damaged."

- Group therapy is typically not indicated for children who have behavioral problems, which may interfere with their ability to participate or their ability to be supportive to other group members. This may include children who are hyperactive, aggressive, abusive, or sexually acting–out. It should be noted that while children with these types of problems may not benefit from group therapy approaches for victimization issues, they may require a group approach that is more specific to their needs (e.g., groups for children with sexual behavior problems).

DEALING WITH THE JUSTICE SYSTEM

It is not unusual for maltreated children and their families to be actively involved with either the Criminal, Juvenile, or Family Court during the course of therapy. The investigation, law enforcement or investigative social worker recommendations, prosecution, hearings, trials, and court outcomes can have a significant impact on the child and family members' emotional, cognitive, and daily functioning. To be effective, mental health professionals must know the status of their client's involvement in the investigative process or court system and work to facilitate both the client's cognitive understanding of this process and the management his/her emotional reactions. Mental health professionals must have knowledge of terminology, roles of criminal justice and child protective services personnel, and local procedural steps and practices.

This knowledge enables the therapist to educate and clarify the client's information and understanding of what is taking place; support the client to obtain assistance or timely, responsive, and appropriate treatment; advocate for the client or serve as a liaison between investigative personnel and the child or child's family,

if indicated; and help clients cope with court decisions that can change their lives either temporarily or, in some cases, permanently.

The therapist can provide advocacy and advice on child protection issues such as:

- the need to place a child in foster care, prevention of multiple placements, or the need for a change in placement;
- informing and preparing the child for a foster care placement or a change in placement;
- assisting the social worker, foster parents, or parents in managing the child's behavior during a transition to foster care or in returning home;
- making recommendations to social workers about visitation or family reunification decisions;
- discussing fears and concerns about court procedures and potential case outcomes, and ways to manage emotional reactions to possible case outcomes;
- preparing the client to manage the stress of court testimony.

The priority is to advocate in the best interests of the child by taking into consideration the child's safety, emotional, and developmental needs. This statement is frequently made and defended from the perspective and context of the person proposing or defending a recommendation. In most of these situations, there are many competing priorities, (e.g., child's needs, parent's desires versus their actual capabilities, investigative and judicial procedures, and local and State policies regarding foster placement and level of care). The safety of the child immediately followed by the emotional and developmental needs of the child should take precedence.

MANAGING THE THERAPEUTIC ENVIRONMENT

Appropriate management of the therapeutic environment supports many aspects of the therapeutic relationship and incorporates a diverse set of characteristics that includes the physical environment, support personnel, and structure of the therapeutic session.

Physical Environment

The physical environment is important to provide a sense of security to the child and family. Therapists should plan to create an atmosphere in which the child and family feel that they are safe, with ample opportunity provided for expressing their concerns, and an environment free of interruption and unnecessary risks and hazards to children (e.g., breakable objects that require constant child monitoring), or hazardous elements (e.g., uncovered electric sockets).

Support Personnel

The first and last agency contact is often with a receptionist or secretarial support person. This individual is in a unique position to provide an atmosphere of warmth, acceptance, and congeniality. In some cases, children or their parents may feel a sense of shame, isolation, or stigmatization as a result of either being maltreated or being involved in therapy. The value of friendly and attentive support personnel cannot be overestimated.

Structure of the Therapeutic Session

Establishing a specific format or routine can facilitate the child or family's ongoing resolution of clinical issues. Children often need physical structure to facilitate their involvement with the therapist and to remember the tasks or objectives of the therapy. By establishing a regular routine, the client develops expectations about the therapist and the therapeutic process, may feel less threatened about involvement in therapy, and more secure about therapy sessions. An example of such a routine related to the structure of the therapeutic session involves the process of greeting the client in the waiting room, walking with the client down the hall, entering the therapy room together, and beginning the session with a similar question or activity (e.g., a question related to issues that may have occurred since the last session or starting a session by playing with a particular toy). This structure also includes setting a specific and acknowledged time for the duration and frequency of sessions.

CONFIDENTIALITY

Clients need to trust mental health professionals, feel free to confide information and concerns, and feel comfortable exploring difficult issues and subject matter. Explaining confidentiality to children and parents will facilitate their understanding of the scope and purpose of evaluation and clinical services. Explanations to children must be tailored to their level of understanding. The statutory duty to report child abuse and neglect, however, is not excused by the patient–psychotherapist privilege. In statements about confidentiality, mental health professionals should be certain that their clients are aware that the following must be reported if they are suspected:

- child abuse, sexual abuse, or neglect;
- threat of suicide or attempted suicide; or
- homicide or threat of homicide.

It is recommended that parents and children be given a confidentiality statement at the beginning of therapy, that the statements be made both verbally and in writing, and that the statements be included with other guidelines regarding the therapeutic relationship. Suggested verbal statements for both a parent and a child are:

- **To Parent:** "What we discuss in therapy is confidential with two exceptions: one, if I think you're going to hurt yourself; two, if I think you're going to hurt someone else, including your child. If either of these two events seems likely, I will need to take protective action, which will include calling appropriate authorities."
- **To Child:** "What we discuss in therapy is confidential with three exceptions: one, if I think you're going to hurt yourself; two, if I think you're going to hurt someone else; and, three if I think someone or something is hurting you, including your parents. When any of those things are going on, I'll need to let someone know and try to get additional help for you."[60]

Release of Information

Clients often feel more comfortable talking about issues and their behavior when they know that clinicians do not talk about their clients outside the clinical setting and understand the conditions and procedures for release of information. In forensic evaluations, clients must be informed about the nature of the evaluation

and that the information will be given to the investigative agency requesting the evaluation. In clinical evaluations and treatment services, clients should be informed that information can be released or exchanged only after a consent form is signed. States' laws regarding the possibility of mental health records being subpoenaed should also be explained to clients.

PERSONAL ISSUES FOR MENTAL HEALTH PROFESSIONALS

Countertransference

Countertransference has been identified and described in the writings on psychoanalytic and psychodynamic theory, but only recently has this internal reaction of therapists been specifically discussed in the child maltreatment literature.[61] Countertransference is defined as the therapist's reactions (feelings, thoughts, statements and behavior) directed toward the client and brought about by the therapist's previous life experiences. A therapist's countertransference reactions may be generated by an aspect of the client's history, the client's presentation, or the interaction between the client and therapist. Examples of factors that may influence the therapist's reactions when working with abused and neglected children and their families include:

- a previous history of child maltreatment;
- early childhood relationships with parents and caretakers;
- existing relationships with his/her own children;
- interactions with the client—child, parent, or family; and,
- previous clients with similar clinical or historical features.

Countertransference is significant in any therapeutic context because it can affect the quality and direction of the psychotherapy. Awareness of the issue is important in providing clinical services to abused and neglected children and families, especially if the therapist has a history of child maltreatment. Some mental health professionals suggest that therapists who have experienced child maltreatment may have inherent difficulties in managing their own reactions. Examples of their concern include biased interpretations of children's behavior, anger toward abusive parents, a perceived lack of participation or progress on the part of the abusive parent, limited or inappropriate interventions with abusive parents, and biased rather than objective recommendations for removal of children from their home or for family reunification.

Further examination of the manifestations of countertransference in psychotherapy with abused and neglected children and their families is needed. Friedrich suggests that therapists often have difficulty with countertransference when they become too rigid in their approach, have numerous unresolved victimization issues, and begin to define themselves as successful only through their therapy.[62] The key to identifying and resolving countertransference issues is the therapist's ability to use the information he/she observes (i.e., think, feel, and/or see) about him/herself in the therapeutic relationship. For example, a therapist who feels deeply saddened as a result of interacting with a client and begins to divert his attention to his own feelings cannot adequately respond to his client. The alert therapist identifies and manages this internal response and converts it toward a sensitive intervention with the client.

Therapists must be alert to countertransference and its impact on their therapeutic interventions. It is helpful to discuss them with a clinical supervisor or colleague to develop objectivity. There is no indication that a

therapist with a history of child maltreatment should not work with abused children and their families as long as potential countertransference reactions are identified and the issues are managed in a way that is beneficial to the client.

Stress and Burnout

Stress and burnout occur in many professions. Working with abused and neglected children and the limitations of the systems designed to help them, however, present a unique set of stressors. Stress and burnout are the most commonly recognized terms to describe professionals' reactions.

Stress is viewed as having physiological, behavioral/emotional, and cognitive components. Physiological reactions can include tightness in the chest, stomach aches, intestinal or bowel problems, hyperventilating, decreased immunity, high blood pressure, or exhaustion. Behavioral reactions can include insomnia, avoidance (arriving late at work/leaving early, disappearing during the workday, noncompletion of assignments); low frustration tolerance (becoming easily emotionally reactive to situations or being short-tempered); or scapegoating other employees or agencies. Emotional reactions include feelings of sadness, anxiety, depression, and feeling lonely and overwhelmed. Examples of cognitive distortions include "all or nothing" thinking, overgeneralization, exclusive focus on the negative and disqualifying the positive, magnifying problems, and feeling responsible for problems without examining whether or not they belong to someone else.[63] Burnout is viewed as the result of failing to cope successfully with stress. Freudenberger suggests that burnout may be manifest as "waning enthusiasm, irritability, and feelings of disengagement caused by stress, pressure, and exhaustion."[64]

Sources of stress most commonly reported in the field of child abuse and neglect are repeated exposure to children's histories of cruelty, abuse, and neglect inflicted by caretakers and the children's adaptations; the realities of working with chaotic, disorganized families or families with abnormal relationships; overwhelming caseloads; anxious, demanding nonoffending parents and relatives; the limitations of the law, the criminal justice system, and social service agencies designed to help children; constantly feeling "unfinished" about work; social policies driven by fiscal resources; feeling unable or unwilling to talk about cases with friends or family; lack of coordination and/or cooperation among public agencies; and agencies and organizations unresponsive to employee stress.

New literature is beginning to evolve on the unique stress experienced by professionals working with victims of trauma. Figley[65] has coined the term "secondary victimization" and McCann and Pearlman[66] have described it as "vicarious traumatization." Both concepts describe the psychological reactions of professionals to working with crime or trauma victims.

MANAGING PROFESSIONAL AND PRIVATE LIVES

To help prevent secondary victimization and burnout, the mental health professional should:

- separate his/her personal and professional lives by balancing work and recreation;
- develop absorbing interests and friends outside the field;
- engage in regular physical activities such as walking, swimming, sports, gardening, etc.;
- take real breaks during the day;

- balance trauma work with nontrauma work, clinical work with nonclinical work (such as teaching, consultation, or research), or direct service with administrative activities;

- attend professional meetings, conferences, and workshops not only to build skills but to develop supportive professional contacts and restorative breaks from the ordinary;

- assess the possibility of a personal basis for workaholic tendencies, (e.g., low self-esteem, unresolved victimization, dissatisfying personal life);

- avoid overcommitment and overextension of work-related activities for prolonged periods of time, (e.g., years);

- meet regularly with other professionals either from the same discipline or from related disciplines to share perspectives and feelings (they may be more supportive than friends or relatives who do not want to hear about the details of this work or cannot understand why mental health and other professionals serving abused and neglected children choose this type of work); and

- establish attainable goals for the week, month, or year and write them down (professionals in this field should avoid the quagmire of "I am not doing enough," with no means of comparing these thoughts to a realistic, measurable list).

RESPONSIBILITIES OF SUPERVISORS, MANAGERS, AND ADMINISTRATORS

Supervisors, managers, and administrators have a responsibility to their employees to create a supportive work environment for staff. Unfortunately, work-related stress has historically been viewed as the employee's problem. Stress from working with abused and neglected children should not be treated as business as usual or burned-out employees as front-line casualties.[67] Managers should consider the following steps to build a positive, supportive organization:

- Assess how well the organization recognizes and responds to the levels of stress experienced by its employees. Are there methods to help people cope built into daily operations? Do any policies worsen the stress employees feel? Symptoms of dysfunction include low morale; high turnover; absenteeism; scapegoated, angry, and frustrated workers; mistrust of management; and lack of cooperation among staff.

- Assess whether the basic causes of job stress exist, such as unclear job descriptions and unrealistic expectations regarding the scope and responsibilities of the position; conflicting workload demands and priorities; an inability or resistance on the part of management to clarify priorities; persistent job overload in which employees have more to do than what they can reasonably accomplish; and lack of problem resolution and employee frustration over problems and issues that constantly reoccur because they are unresolved.

- Discuss the problems with employees to obtain their perspective. Develop action plans to address the issues and keep employees informed about progress toward resolution as well as about obstacles and setbacks.

- Identify and reduce employee isolation by encouraging camaraderie and the development of a common base of experience through informal and formal group activities. Promote consultation,

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problem solving, and decisionmaking to both reduce the burden on individual employees and encourage the creation of new approaches and alternatives.

- Provide consultation and regular supervision for employees to reduce feelings of isolation, recognize work-related stress, and validate employees and their work.

- Create an environment in which employees feel valued and their work is recognized. Celebrate accomplishments, no matter how small or incremental. Involve employees in planning and implementing activities that will make them feel supported and appreciated. Build intra-agency support systems so that employees feel part of a broader network of professionals striving to serve the target population.

- Assert and act on the belief that the mental health and personal effectiveness of employees are as important as the needs of the clients they serve.

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OTHER RESOURCES

PROFESSIONAL ASSOCIATIONS

American Academy of Pediatrics
141 Northwest Point Boulevard
P.O. Box 927
ELk Grove, IL 6009-0927
800/433-9016

American Association of Marriage and Family Therapy
1100 17th Street, N.W.
Washington, DC 20036
202/452-0109

American Professional Society on the Abuse of Children
332 South Michigan Avenue
Suite 1600
Chicago, IL 60604
312/554-0166

American Psychiatric Association
1400 K Street, N.W.
Washington, DC 20005
202/682-6000

American Psychological Association
750 First Street, N.E.
Washington, DC 20002-4242
202/336-5500

Child Welfare League of America
440 First Street, N.E.
Suite 310
Washington, DC 2001-2085
202/638-2952

Clearinghouse on Child Abuse and Neglect Information
P.O. Box 1182
Washington, DC 20013
703/385-7565

National Association of Counsel for Children
1205 Oneida Street
Denver, CO 80220
303/321-3963

National Association of Social Workers
750 First Street, N.E.
Suite 700
Washington, DC 20002
202/408-8600

Parents Anonymous
6733 South Sepulveda Boulevard
Suite 270
Los Angeles, CA 90045
800/421-0353

People of Color Leadership Institute
714 G Street, N.E.
Washington, DC 20003
202/544-3144

PROFESSIONAL JOURNALS

Journals Specific to Family Violence

Child Abuse and Neglect: The International Journal

Journal of Child Sexual Abuse

Journal of Family Issues

Journal of Family Violence

Journal of Interpersonal Violence

Psychology of Women Quarterly

Violence and Victims

Related Journals

American Journal of Family Relations

American Journal of Orthopsychiatry

Archives of Sexual Behavior

Child Welfare

Children and Youth Services Review

Criminal Justice and Behavior: An International Journal

Journal of Social Issues

Pediatrics

Professional Psychology: Research and Practice

Psychotherapy

Social Casework

Social Work

GLOSSARY OF TERMS

Aberrant Relationships - associations, affiliations, or kinships characterized by patterns of behavior deviating from societal norms.

Adjudicatory Hearings - held by the Juvenile/Family Court to determine whether a child has been maltreated or whether some other legal basis exists for the State to intervene to protect the child. Each State has its own terms and definitions in the jurisdiction provisions of its law.

Anorexia Nervosa - eating disorder characterized by refusal to maintain body weight over a minimal normal weight for age and height; intense fear of gaining weight or becoming fat, even though underweight.

Attachment Theory - a developmental theory that emphasizes the relationship between an infant and its caretaker(s). Typically, attachment theory states that the preliminary framework for relationship patterns is established through early childhood relationships (i.e., through interactions with parents and siblings), but this framework is malleable and subject to change throughout an individual's lifespan.

Behavioral Theory - initially established by John B. Watson, the theory that overt behavior is the sole basis for scientific psychology. Founded on operant conditioning principles, behavioral theory attempts to explain the cause–effect relationship between the class of stimulus variables and response variables, with reinforcement stimuli increasing behaviors and punishment stimuli decreasing behaviors.

Bulimia - eating disorder in which there are recurring episodes of binge eating; a sense of lack of control over eating behavior during the binges; self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercising to prevent weight gain.

Case Plan - the professional document that outlines the outcomes, goals, and strategies to be used to change the conditions and behaviors resulting in child abuse and neglect.

Case Planning - the stage of the child protection process whereby the CPS caseworker and other treatment providers develop a case plan with the family members.

Child Protective Services (CPS) - the designated social service agency (in most States) to receive reports, investigate, and provide rehabilitation services to children and families with problems of child maltreatment. Frequently, this agency is located within larger public social services agencies, such as Departments of Social Services or Human Services.

Cognitive Functioning - awareness of objects, thoughts, or perceptions.

Cognitive Theory - as a development of behavioral theory, cognitive or cognitive–behavioral approaches aim to change behavior by changing an individual's cognition (awareness, perceptions).

Confidentiality - a provision in all State child abuse and neglect reporting laws that protects the privacy of children and families by not permitting information about the finding of the child maltreatment report to be released to other agencies without permission of the family. In some States, members of multidisciplinary teams may receive information without a release of information.

Countertransference - the conscious and unconscious emotional reaction of the professional to the client.

Disposition Hearing - held by the Juvenile/Family Court to determine the disposition of children after cases have been adjudicated, such as whether placement of the child in out-of-home care is necessary and what services the children and family will need to reduce the risk and address the effects of maltreatment.

Emergency Hearings - held by the Juvenile/Family Court to determine the need for emergency out-of-home placement of a child who may be a victim of maltreatment. If out-of-home placement is found to be unnecessary by the court, other measures, including mandatory participation by a parent in a drug abuse treatment program, attendance at a parenting skills class, or regular meetings with a mental health professional, may be ordered to protect the child.

Evaluation of Family Progress - the stage of the child protection case process (after the case plan has been implemented) when the CPS caseworker and other treatment providers evaluate and measure changes in the family behaviors and conditions which led to child abuse and neglect, monitor risk elimination/reduction, and determine when services are no longer necessary. Frequently, community treatment providers coordinate their evaluation of case progress through periodic team meetings.

Family Assessment - the stage of the child protection process when the CPS caseworker, community treatment providers, and the family reach a mutual understanding regarding the most critical treatment needs that must be addressed and the strengths on which to build.

Family Preservation/Reunification - the philosophical belief of social services agencies that children and families should remain together if the safety of the children can be ensured.

Family Systems Theory - a view of how family members interact with one another in relationship patterns that promote and/or accommodate the functioning of the family as a unit (or system).

Forensic Evaluation - a medical or psychological evaluation used for investigations or for submission to court.

Good Faith - the standard used to determine if a reporter has reason to suspect that child abuse or neglect has occurred.

Histrionic Personality Disorder - a pervasive pattern of excessive emotionality and attention-seeking behavior, usually beginning in early childhood, sometimes referred to as hysterical personality.

Ideation - the formation of images and objects in the mind.

Immunity - established in all child abuse laws to protect reporters from civil lawsuits and criminal prosecution resulting from filing a report of child abuse and neglect. Immunity is provided as long as the report is made in good faith.

Initial Assessment - the stage of the child protection case process when the CPS caseworker and other treatment providers determine the validity of the child maltreatment report, assess the risk of maltreatment, and determine the safety of the child and the need for further intervention. Frequently, medical, mental health, and other community providers are involved in assisting in the initial assessment.

Interpersonal Functioning - behavior that refers to relationships among individuals.

Intersystemic Functioning - behavior that refers to relationships among systems.

Intrapersonal Functioning - behavior that is focused within the individual.

Juvenile and Family Courts - established in most States to resolve conflict and otherwise intervene in the lives of families in a manner that promotes the best interest of children. These courts specialize in areas such as child maltreatment, domestic violence, juvenile delinquency, divorce, child custody, and child support.

Learning Theory - in clinical work and therapy, learning theory is typically referred to as social learning theory, which assesses the synergistic effects of behavior, personal factors, and the environment. This may involve observational learning, modeling, and/or cognitions.

Life Adjustment Problems - an individual's involvement in common developmental adjustments and problems that may result in temporary and/or situational distress and decrease in functioning. This typically involves transitions throughout an individual's lifespan (e.g., beginning of elementary school, puberty, moving away from one's family for the first time) or shifts in interpersonal relationships (e.g., divorce, death of a family member).

Maladaptive Traits - interpersonal or intrapersonal traits or characteristics that impair an individual's normal adaptive process.

Mandated Reporter - one who in his/her professional capacity is required by State law to report "suspected" cases of child maltreatment to the designated State agency. Some States clearly define that teachers, principals, nurses, and counselors are included.

Mediating Variables - factors that affect, offset, or influence (negatively or positively) an anticipated cause-and-effect relationship.

Modalities - approaches to psychotherapy including individual, group, or family therapy.

Multidisciplinary Team - established between agencies and professionals to mutually discuss cases of child abuse and neglect and aid decisions at various stages of the child protection systems case process. These teams may also be designated by different names, including child protection teams, interdisciplinary teams, or case consultation teams.

Multiple Personality Disorder - the existence within the individual of two or more distinct personalities.

Object Relations - in Freudian theory, the emotional attachment to another person. As described by neo-Freudians, this term has been broadened to encompass the development of the capacity to engage and maintain a significant interpersonal relationship with a primary significant other (e.g., primary caregiver). Recently, theoreticians have developed therapeutic approaches based on problems associated with interpersonal relationships, which are presumed to be based on fundamental tenets of an individual's child-caregiver relationship.

Out-of-Home-Care - child care, foster care, or residential care provided by persons, organizations, and institutions to children who are placed outside of their families, usually under the jurisdiction of Juvenile/Family Courts.

Personality Disorders - the implication of inflexible and maladaptive patterns of behavior, of sufficient severity to cause either significant impairment in adaptive functioning or subjective distress.

Primary Prevention - activities geared to a sample of the general population to prevent child abuse and neglect from occurring.

Psychoanalysis - a psychotherapeutic technique relying on free association, dream interpretation, play, and the analysis of resistance and transference to provide insight into the unconscious roots of disrupted behavior.

Psychodynamic Theory - the Freudian and neo-Freudian theories that attempt to understand the basic motivations of human behavior. Both emotions and unconscious motivations play major roles throughout an individual's lifespan.

Psychopathology - the branch of medicine dealing with causes and nature of mental disease.

Psychosexual - pertaining to the mental or emotional aspects of sex.

Psychotherapy - a method of treatment designed to produce a response by mental rather than physical stimulus; it includes the use of suggestion, persuasion, reeducation, reassurance, and support as well as hypnosis and psychoanalysis.

Psychosomatic - physical symptoms of mental, emotional, or psychic origin.

Reality Testing - verbal interaction or behavior directed toward distinguishing between a person's subjective reaction and others' views of the same event; or the assessment of another's ability to accurately perceive other individuals' intentions and/or behavior.

Reasonable Efforts - as required by State law, the State child welfare agency must make reasonable efforts to keep the family together or, if the child has already been removed, to reunify the family. Before a State may receive Federal financial support for the costs resulting from a child's removal from home into out-of-home care, a judge must determine that reasonable efforts have been made to keep the family together. Similarly, placement may not be continued with Federal support without a finding by the judge that such efforts have been made to reunite the family.

Review Hearing - held by the Juvenile/Family Court to review dispositions (usually every 6 months) to determine the need to maintain placement in out-of-home care and/or court jurisdiction of a child. Every State requires State courts, agency panels, or citizen review boards to hold periodic review to reevaluate the child's circumstances if he/she has been placed in out-of-home care.

Risk Assessment - an assessment and measurement of the likelihood that a child will be maltreated in the future, usually through the use of checklists, matrices, scales, and/or other methods of measurement.

Risk Factors - behaviors and conditions present in the child, parent, and/or family that will likely contribute to future occurrence of child maltreatment.

Role Theory - a view of how an individual may have a relationship that includes behavioral expectations ascribed to each role (e.g., parent-child, employer-employee, husband-wife).

Secondary Prevention - activities targeted to prevent breakdowns and dysfunctions among families who have been identified as at risk for abuse and neglect.

Substantiated - a finding made by CPS after investigating a child abuse or neglect report indicating that credible evidence exists to support that child maltreatment did occur. The criteria used to substantiate a report are different in each State. Other terms used in some States are "indicated," "validated," or "founded."

Tertiary Prevention - treatment efforts geared to address situations in which child maltreatment has already occurred with the goals of preventing any further future child maltreatment as well as avoiding the harmful effects of child maltreatment.

Transference - the unconscious transfer of feelings of hostility or affection from the patient to the professional.

Treatment - the stage of the child protection process whereby specific treatment services geared to the reduction of risk of maltreatment are provided by mental health and other social services professionals.

Unsubstantiated - a finding made by CPS after investigating a child abuse or neglect report indicating that credible evidence *does not* exist to support that child maltreatment occurred. In some States, the term "unfounded" is used.

APPENDIX A

STATE VICTIMS OF CRIME PROGRAMS

CRIME VICTIM COMPENSATION AND VICTIM ASSISTANCE

APPENDIX A

STATE VICTIMS OF CRIME PROGRAMS

CRIME VICTIM COMPENSATION AND VICTIM ASSISTANCE

STATE	VICTIM COMPENSATION	VICTIM ASSISTANCE
Alabama	Executive Director Alabama Crime Victims Compensation Commission 645 S. McDonough Street P.O. Box 1548 Montgomery, AL 36102-1548 (205) 242-4007 FAX (205) 240-3328	Director Alabama Department of Economic and Community Affairs Law Enforcement Planning Division 401 Adams Avenue Montgomery, AL 36103-5690 (205) 242-5100 cc: Section Chief (205) 242-5891 FAX (205) 242-5515
Alaska	Administrator Department of Public Safety Violent Crimes Compensation Board P.O. Box 111200 Juneau, AK 99811-1200 (907) 465-3040	Commissioner Department of Public Safety Council on Domestic Violence and Sexual Assult P.O. Box 111200 Juneau, AK 99811-1200 (907) 465-4356 cc: Executive Director FAX (907) 465-3627
American Samoa	No Compensation Program DC Contact: American Samoa Federal Program Coordinator 413 Cannon House Office Building Washington, DC 20515 (202) 225-8577 FAX (202) 225-8757	Director Department of Human Resources American Samoa Government Pago Pago, American Samoa 96799 (011)(684) 633-4485 cc: Social Services Division (011)(684) 633-2696 FAX (011)(684) 633-1139
Arizona	Executive Director Arizona Criminal Justice Commission 1501 W. Washington, Suite 207 Phoenix, AZ 85007 (602) 542-1928 cc: Victim Services Coordinator FAX (602) 542-4852	Director Arizona Department of Public Safety P.O. Box 6638 Phoenix, AZ 85005 (602) 223-2000 cc: Fiscal Management and Support (602) 223-2491/2650 FAX (602) 223-2347
Arkansas	Attorney General Office of the Attorney General Crime Victims Reparations Board 323 Center Street, Suite 601 Little Rock, AR 72201 (501) 682-1323 cc: Director FAX (501) 682-8084	Prosecutor Coordinator Prosecutor Coordinator's Office 232 Center Street, Suite 750 Little Rock, AR 72201 (501) 682-5045 cc: V/W Coordinator (501) 682-5045 FAX (501) 682-5004

California	Executive Officer State of California State Board of Control P.O. Box 3036 Sacramento, CA 95812-3036 (916) 323-6251 cc: Deputy Director Victims of Crime Program (916) 323-6251 FAX (916) 327-2933	Executive Director Office of Criminal Justice Planning 1130 K Street, Suite 300 Sacramento, CA 95814 (916) 324-9140 (916) 323-7611 FAX (916) 327-8711
Colorado	Director Division of Criminal Justice Department of Public Safety 700 Kipling Street, Suite 3000 Denver, CO 80215 (303) 239-4442/4451 cc: Criminal Justice Specialist FAX (303) 239-4491	Director Division of Criminal Justice Department of Public Safety 700 Kipling Street, Suite 3000 Denver, CO 80215 (303) 239-4442/4451 cc: Criminal Justice Specialist FAX (303) 239-4485
Connecticut	Administrator Commission on Victim Services 1155 Silas Deane Highway Wethersfield, CT 06109 (203) 529-3089 FAX (203) 721-0593	Under Secretary Office of Policy and Management Policy and Planning Division 80 Washington Street Hartford, CT 06106 (203) 566-4298 cc: Planning Specialist FAX (203) 566-6295
Delaware	Executive Director Delaware Violent Crimes Compensation Board 1500 East Newport Pike, Suite 10 Wilmington, DE 19804 (302) 995-8383 cc: Support Services Administrator FAX (302) 995-8387	Executive Director Criminal Justice Council Carvel State Office Building 820 North French, Fourth Floor Wilmington, DE 19801 (302) 577-3437 (302) 577-3432 FAX (302) 577-3440
District of Columbia	Director Department of Employment Services Employment Security Building 500 C Street, N.W., Suite 600 Washington, DC 20001 (202) 639-1000 Crime Victims' Compensation Program 1200 Upshur Street, N.W., Suite 100 Washington, DC 20001 (202) 576-7090 FAX (202) 576-7282	Director Department of Human Services 801 North Capitc' Street, N.W. Washington, DC 20002 (202) 727-0310 cc: Director Crime Victim Assistance Center First and I Streets, S.W., Room 116 Washington, DC 20024 (202) 842-8467

Florida	Chief and Director 2012 Capital Circle, S.E. Hartman Building, Room 104 The Capitol Tallahassee, FL 32399-1050 (904) 488-0848 FAX (904) 487-1595	Director Office of the Attorney General Division of Victims Services and Criminal Justice Programs The Capitol Tallahassee, FL 32399-1050 (904) 488-0848 (904) 487-4760 FAX (904) 487-1595
Georgia	Director Georgia Crime Victims Compensation Program Criminal Justice Coordinating Council 503 Oak Place, Suite 540 Atlanta, GA 30349 (404) 559-4949 cc: Program Director	Director Criminal Justice Coordinating Council 503 Oak Place, Suite 540 Atlanta, GA 30349 (404) 559-4949 FAX (404) 559-4960
Guam	No Compensation Program	Attorney General Department of Law Government of Guam 2-200 East Guam Judicial Center 120 West O'Brien Drive Agana, GU 96910 (011)(671) 475-3406 FAX (011)(671) 472-2493
Hawaii	Attorney General Resource Coordination Division 425 Queen Street, Room 221 Honolulu, HI 96813 (808) 586-1154 cc: Administrator FAX (808) 548-1900 cc: Director Crime Victims Compensation (808) 587-1143	Attorney General Department of the Attorney General 425 Queen Street, Room 221 Honolulu, HI 96813 (808) 586-1282 cc: Administrator FAX (808) 548-1900
Idaho	Executive Director Crime Victims Compensation Program c/o Idaho Industrial Commission 317 Main Street Boise, ID 83720 (208) 334-6000 cc: Manager Victim Compensation Program FAX (208) 334-2321	Executive Director Idaho Department of Health and Welfare Council on Domestic Violence 450 West State Street Boise, ID 83720-9990 (208) 334-5580 FAX (208) 334-5694

Illinois	Deputy Clerk Illinois Court of Claims 630 South College Street Springfield, IL 62756 (217) 782-7101 cc: Chief Crime Victims Division Office of the Attorney General 100 West Randolph, 13th Chicago, IL 60601 (312) 814-2581	Executive Director Illinois Criminal Justice Information Authority 120 South Riverside Plaza, Tenth Floor Chicago, IL 60606 (312) 793-8550 cc: Program Supervisor FAX (312) 793-8422
Indiana	Acting Director Violent Crimes Compensation Bureau Indiana Government Center, South 402 West Washington Street, Room W382 Indianapolis, IN 46204 (317) 232-7103 FAX (317) 232-4331	Executive Director Indiana Criminal Justice Institute 302 West Washington Street, E209 Indianapolis, IN 46204 (317) 232-1233 cc: V/A Grant Coordinator (317) 232-1233
Iowa	Attorney General Office of the Attorney General Hoover State Office Building Des Moines, IA 50191 (515) 242-6110 cc: Deputy Director Iowa Department of Justice Crime Victim Assistance Program Old Historical Building Des Moines, IA 50319 FAX (515) 281-8199	Attorney General Office of the Attorney General Hoover State Office Building Des Moines, IA 50191 (515) 242-6109 cc: Administrator Iowa Department of Justice Crime Victim Assistance Program Old Historical Building Des Moines, IA 50319 FAX (515) 281-8199
Kansas	Attorney General Office of the Attorney General Kansas Crime Victims Compensation Board Jayhawk Tower, Suite 400 700 Southwest Jackson Topeka, KS 66603-3741 (913) 296-2359 cc: Director FAX (913) 296-0652	Secretary Department of Social and Rehabilitation Services Crime Victim Assistance Program Docking State Office Building 915 Southwest Harrison, Room 600 North Topeka, KS 66612-1570 (913) 296-3271 cc: Community Resource Development SRS-Youth and Adult Services Smith/Wilson Building 300 Southwest Oakley Topeka, KS 66606 (913) 296-7465 FAX (913) 296-4649

Kentucky	Executive Director Crime Victims Compensation Board 115 Myrtle Avenue Frankfort, KY 40601-3113 (502) 564-7986 FAX (502) 564-3151	Secretary Kentucky Justice Cabinet Bush Building 403 Wapping Street, Second Floor Frankfort, KY 40601 (502) 564-7554 cc: VOCA Program Director FAX (502) 564-6615
Louisiana	Executive Director Crime Victims Reparations Program Louisiana Commission on Law Enforcement 1885 Wooddale Boulevard, Suite 708 Baton Rouge, LA 70806-1442 (504) 925-1997 cc: Program Manager (504) 925-4437 FAX (504) 925-1998	Executive Director Louisiana Commission on Law Enforcement 1885 Wooddale Boulevard, Suite 708 Baton Rouge, LA 70806-1442 (504) 925-1997 cc: Program Specialist (504) 925-4437 FAX (504) 925-1998
Maine	Office of the Attorney General State House Station 6 Augusta, ME 04333 (207) 626-8500	Commissioner Maine Department of Human Services Division of Purchased and Support Services State House Station 11 Augusta, ME 04333 (207) 289-2736 cc: Evaluation Manager (207) 289-5060
Maryland	Secretary Department of Public Safety and Correctional Services Criminal Injuries Compensation Board 6776 Reisterstown Road, Suite 313 Baltimore, MD 21215-2340 (410) 764-4078 cc: Director (410) 764-4214	Secretary State of Maryland Department of Human Resources 311 West Saratoga Street, Room 239 Baltimore, MD 21201 (410) 333-0059 cc: Director Women's Services Programs Community Services Administration FAX (410) 333-0392
Massachusetts	Attorney General Department of the Attorney General One Ashburton Place, Room 1800 Boston, MA 02108-1698 (617) 727-2200 cc: Chief Victim Compensation Division Office of the Attorney General One Ashburton Place, Room 1811 Boston, MA 02108-1698 (617) 727-2200 ext. 2875 FAX (617) 727-3251	Executive Director The Commonwealth of Massachusetts Victim and Witness Assistance Board Massachusetts Office for Victims Assistance 100 Cambridge Street, Room 1104 Boston, MA 02202 (617) 727-5200 cc: Grant Manager FAX (617) 727-6522

Michigan	Administrator Crime Victims Compensation Board P.O. Box 30026 Lansing, MI 48909 (517) 373-0979 320 South Walnut 1st Floor North Lansing, MI 48933 FAX (517) 373-1071	Director Grants Management Division Office of Contract Management P.O. Box 30026 Lansing, MI 48909 (517) 373-6655 (517) 373-1826 FAX (517) 335-2355
Minnesota	Commissioner Department of Public Safety Department of Transportation Building Room 211, John Ireland Boulevard St. Paul, MN 55155 (612) 296-6642 cc: Executive Director Crime Victims Reparation Board Griggs-Midway Building 1821 University Avenue, N-465 St. Paul, MN 55104 (612) 649-5993 FAX (612) 645-0963	Commissioner Department of Corrections 300 Bigelow Building 450 North Syndicate Street St. Paul, MN 55104 (612) 642-0395 (612) 642-0221 FAX (612) 642-0223
Mississippi	Director Department of Finance and Administration Box 267 Jackson, MS 39205 (601) 359-6766 cc: Hearing Officer (601) 359-6766 FAX (601) 359-2470	Director Department of Public Safety Division of Public Safety Planning 301 West Pearl Street Jackson, MS 39203 (601) 949-2225 FAX (601) 960-4263
Missouri	Director Division of Workers' Compensation Crime Victims Compensation P.O. Box 58 Jefferson City, MO 65102 (314) 751-4231 cc: Supervisor 3315 West Truman Boulevard FAX (314) 751-2012	Director Department of Public Safety Truman Building, Room 870 P.O. Box 749 Jefferson City, MO 65102-0749 (314) 751-4905 cc: Program Specialist
Montana	Administrator Board of Crime Control Division Crime Victims Unit Scott Hart Building 303 North Roberts, Fourth Floor Helena, MT 59620-1408 (406) 444-3605 cc: Administrative Officer (406) 444-3653 FAX (406) 444-4722	Administrator Board of Crime Control Division Crime Victims Unit Scott Hart Building 303 North Roberts, Fourth Floor Helena, MT 59620-1408 (406) 444-3605 cc: Victim Coordinator (406) 444-3604/2649 FAX (406) 444-4722

Nebraska	Executive Director Nebraska Crime Victims Reparation Board Nebraska Commission on Law Enforcement and Criminal Justice 301 Centennial Mall South P.O. Box 94946 Lincoln, NE 68509 (402) 471-2194 cc: Federal Aid Administration (402) 471-2194	Executive Director Nebraska Crime Victims Reparation Board Nebraska Commission on Law Enforcement and Criminal Justice 301 Centennial Mall South P.O. Box 94946 Lincoln, NE 68509 (402) 471-2194 cc: Federal Aid Administration FAX (402) 471-2837
Nevada	Director Nevada Department of Administration Capitol Complex 209 East Musser, Room 204 Carson City, NV 89710 (702) 687-4065	Director Nevada Department of Human Resources 505 East King Street, Room 600 Carson City, NV 89710 (702) 687-5943 FAX (702) 687-4773
New Hampshire	Director of Administration New Hampshire Department of Justice 25 Capitol Street, State House Annex Concord, NH 03301-6397 (603) 271-3658 cc: Victims' Compensation Coordinator (603) 271-1284 FAX (201) 648-3937	Director of Administration New Hampshire Department of Justice State House Annex 25 Capitol Street Concord, NH 03301-6397 (603) 271-3658 (603) 271-1297 FAX (603) 271-2361
New Jersey	Chairman Violent Crimes Compensation Board 60 Park Place, 20th Floor Newark, NJ 07102 (201) 648-2107 cc: Board Accountant (201) 648-2107, ext. 25/20 FAX (201) 648-3937	Attorney General New Jersey Department of Law and Public Safety Division of Criminal Justice Office of Victim/Witness Advocacy 25 Market Street, CN 085 Trenton, NJ 08625-0085 (609) 984-4499
New Mexico	Director New Mexico Crime Victims Reparation Commission 8100 Mountain Road, N.E., Suite 106 Albuquerque, NM 87110 (505) 841-9432 FAX (505) 841-9435	Director New Mexico Crime Victims Reparation Commission 8100 Mountain Road, N.E., Suite 106 Albuquerque, NM 87110 (505) 841-9432 FAX (505) 841-9435
New York	Chairman Crime Victims Board 270 Broadway, Room 200 New York, NY 10007 (212) 417-5133 cc: Administrative Officer New York Crime Victims Board 845 Central Avenue, South 3, Suite 107 Albany, NY 12206 (518) 457-8063 FAX (518) 457-8658	Chairman Crime Victims Board 270 Broadway, Room 200 New York, NY 10007 (212) 417-5133 FAX (212) 587-5133 cc: Director New York Crime Victims Board 845 Central Avenue, South 3, Suite 107 Albany, NY 12206 (518) 457-1779 FAX (518) 457-8658

North Carolina	Director North Carolina Victims Compensation Commission Department of Crime Control and Public Safety Division of Victim and Justice Services P.O. Box 27687 Raleigh, NC 27611-7687 (919) 733-7974 FAX (919) 733-0296	Executive Director Governor's Crime Commission Department of Crime Control and Public Safety P.O. Box 27687 Raleigh, NC 27611 (919) 733-5013 cc: Criminal Justice Planner FAX (919) 733-7585
North Dakota	Director Workers Compensation Bureau Crime Victims Reparation Program Russel Building, Highway 83 North 4007 North State Street Bismarck, ND 58501 (701) 224-3800, (701) 224-3770 cc: Administrator FAX (701) 224-3820	Director Workers Compensation Bureau Crime Victims Reparation Program Russel Building, Highway 83 North 4007 North State Street Bismarck, ND 58501 (701) 224-3800/3770 cc: Administrator FAX (701) 224-3820
North Mariana Islands	No Compensation Program	Executive Director Criminal Justice Planning Agency P.O. Box 1133 CK Saipan MP Saipan, Mariana Islands 96950 (011)(670) 322-9350/6311 cc: Criminal Justice Planner FAX (011)(670) 322-6311 DC Area Office 2121 R Street, N.W. Washington, DC 20008 (202) 673-5869
Ohio	Clerk Victims of Crime Compensation Program Court of Claims of Ohio 65 East State Street, Suite 1100 (614) 466-8439 cc: Director (614) 466-3345 FAX (614) 644-8553	Attorney General Office of the Attorney General 30 East Board Street, 26th Floor Columbus, OH 43266-0410 (614) 466-3376 cc: Executive Director (614) 466-5610 FAX (614) 466-6090
Oklahoma	Executive Director Crime Victims Compensation Board 2200 Classen Boulevard, Suite 1800 Oklahoma City, OK 73106-5811 (405) 521-2330 cc: Administrator FAX (405) 525-3584	Executive Director District Attorneys Council 2200 Classen Boulevard, Suite 1800 Oklahoma City, OK 73106-5811 (405) 521-2349 cc: Administrator FAX (405) 525-3584

Oregon	Attorney General Department of Justice Crime Victims' Compensation Program 240 Cottage Street Salem, OR 97310 (503) 378-5348 cc: Director	Program Monitor The Honorable Charles Crookham Attorney General Office of the Attorney General Special Compensation Program 100 Justice Building Salem, OR 97310 (503) 378-5348 cc: Director (503) 373-1936
Palau	No Compensation Program DC Contact 444 North Capitol Street, N.W. Suite 308 Washington, DC 20001 (202) 624-7793 FAX (202) 624-7795	Vice President Ministry of Justice P. O. Box 100 Koror, Palau 96940 (680) 488-2702 cc: Legal Counsel to the Vice President D.C. Contact 444 North Capitol Street, N.W., Suite 308 Washington, DC 20001 (202) 624-7793 FAX (202) 624-7795
Pennsylvania	Chairman Pennsylvania Crime Victim's Compensation Board Harristown Building No. 2, Lobby Level 333 Market Street Harrisburg, PA 17101 (717) 783-5153	Executive Director Pennsylvania Commission on Crime and Deliquency P.O. Box 1167 Federal Square Station Harrisburg, PA 17108-1167 (717) 787-8559 cc: Program Manager FAX (717) 783-7713
Puerto Rico	No Compensation Program	Attorney General Department of Justice P.O. Box 192 San Juan, PR 00902 (809) 725-0335 cc: Director Planning, Federal, and Statistics Division (809) 725-6144
Rhode Island	State Court Administrator Rhode Island Supreme Court State Court Administrative Office Crime Compensation Program Licht Judicial Complex 250 Benefit Street Providence, RI 02903 (401) 277-3263 cc: State Coordinator Judicial Planning Section RI Supreme Court (401) 277-2500 x 33 FAX (401) 277-3865	Director of Administration Governor's Justice Commission Executive Department 222 Quaker Lane, Suite 100 Warwick, RI 02886 (401) 277-2620 cc: Executive Director FAX (401) 277-1294

South Carolina	Director State Office of Victim Assistance P.O. Box 210009 Columbia, SC 29221-0009 (803) 737-9465 cc: Deputy Director (803) 737-9465 FAX (803) 731-1428	Director Division of Public Safety Office of the Governor Edgar Brown Building 1205 Pendleton Street Columbia, SC 29201 (803) 734-0425 cc: VOCA Program Coordinator (803) 734-0369 FAX (803) 734-0486
South Dakota	Assistant Secretary South Dakota Department of Corrections Joe Foss Building 523 East Capitol Pierre, SD 57501 (605) 773-3478	Director Community Assistance Program South Dakota Department of Commerce and Regulation 910 East Sioux, c/o 500 East Capitol Pierre, SD 57501-5070 (605) 773-3177
Tennessee	State Treasurer Treasury Department First Floor, State Capitol Nashville, TN 37219 (615) 741-2956 cc: Director Division of Claims Administration 11th Floor, Andrew Jackson Building Nashville, TN 37243-0243 (615) 741-2734 FAX (615) 741-7328	Commissioner Department of Human Services Citizens Plaza Building 400 Deaderick Street Nashville, TN 37219 (615) 741-3241 cc: VOCA Specialist (615) 741-5947 FAX (615) 741-4165
Texas	Chief Crime Victims Compensation Division Office of the Attorney General P.O. Box 12548, Capitol Station Austin, TX 78711-2548 (512) 462-6414 cc: Assistant Chief FAX (512) 462-6449	Acting Director Criminal Justice Division Office of the Governor P.O. Box 12428 Capitol Station Austin, TX 78711 (512) 463-1919 cc: Program Manager FAX (512) 463-1932
Utah	Director Office of Crime Victim Reparations 350 East 500 South, Suite 200 Salt Lake City, UT 84111 (801) 533-4000 FAX (801) 533-4127	Director Office of Crime Victim Reparations 350 East 500 South, Suite 200 Salt Lake City, UT 84111 (801) 533-4000 cc: Program Coordinator FAX (801) 533-4127

Vermont	Executive Director Vermont Crime Victims Compensation Program P.O. Box 991 Montpelier, VT 05601-0991 (802) 828-3374	Secretary Agency of Human Services 103 South Main Street Waterbury, VT 05676 (802) 241-2220 cc: Grant Administrator (802) 241-2928 Planning Division FAX (802) 244-8103
Virginia	Chairman Division of Crime Victim's Compensation P.O. Box 1794 Richmond, VA 23214 (804) 367-8686 cc: Director Division of Crime Victim's Compensation P.O. Box 5423 Richmond, VA 23220 (804) 367-8686 FAX (804) 367-9740	Director Department of Criminal Justice Services 805 East Broad Street, Tenth Floor Richmond, VA 23219 (804) 786-4000 cc: Program Manager (804) 786-4001 FAX (804) 371-8981
Virgin Islands	Executive Secretary Virgin Island Criminal Victims Compensation Commission Department of Human Services Office of the Commissioner Barbel Plaza South Charlotte Amalie St. Thomas, VI 00802 (809) 774-1166 cc: Administrator Crime Victim Compensation Commission FAX (809) 774-3466	Governor's Drug Policy Advisor Law Enforcement Planning Commission 116-164 Submarine Base Estate Nisky No. 6, Southside Quarters St. Thomas, VI 00802 (809) 774-6400 cc: Director Victim Witness Services FAX (809) 774-1361
Washington	Director Crime Victim Compensation Program Department of Labor and Industries Olympia, WA 98504 (206) 753-6307 cc: Program Manager (206) 956-5340 Department of Labor and Industries Crime Victims Compensation Program 7373 Linderson Way, S.W. P.O. Box 44520 Olympia, WA 98504-4520	Secretary Department of Social and Health Services Mail Stop 45710 12th and Jefferson Olympia, WA 98504-5710 (206) 753-3395 cc: Program Director Division of Children and Family Services (206) 586-8254 FAX (206) 586-5874

West Virginia	Clerk West Virginia Court of Claims Crime Victims Compensation Fund Room 6, Building 1, State Capitol Charleston, WV 25305 (304) 558-3471 (304) 558-3471 FAX (304) 357-7829	Manager Criminal Justice and Highway Safety Office West Virginia Development Office 1204 Kanawha Boulevard, East Charleston, WV 25301 (304) 558-3814 cc: Federal Program Coordinator FAX (304) 558-0391
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APPENDIX B

OTHER USER MANUALS
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A Coordinated Response to Child Abuse and Neglect: A Basic Manual

Child Protective Services: A Guide for Caseworkers

Caregivers of Young Children: Preventing and Responding to Child Maltreatment

The Role of Educators in the Prevention and Treatment of Child Abuse and Neglect

The Role of Law Enforcement in the Response to Child Abuse and Neglect

Working With the Courts in Child Protection

Protecting Children in Military Families: A Cooperative Response

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